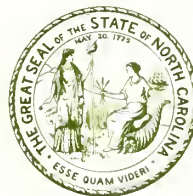


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THE UNIVERSITY OF NORTH CAROLINA
DIVISION OF VOCATIONAL REHABILITATION

FINAL REPORT
of
Comprehensive Statewide Planning
for
Vocational Rehabilitation Services
in the
STATE of NORTH CAROLINA



Division of Vocational Rehabilitation
Department of Public Instruction

and

North Carolina Commission for the Blind
Raleigh, North Carolina

PLANNING DIRECTOR
JOE C. MORROW

Planning Period: January 1, 1967-December 31, 1968
Report Date: December 31, 1968

FINAL REPORT

**Comprehensive Statewide Planning for
Vocational Rehabilitation Services**

North Carolina

**Division of Vocational Rehabilitation
Department of Public Instruction
Raleigh, North Carolina**

and

**North Carolina Commission for the Blind
410 NORTH BOYLAN AVENUE
Raleigh, North Carolina**

**JOE C. MORROW
PLANNING DIRECTOR**

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"This planning program was supported by a grant, under Section 4(a)(2)(b), from the Rehabilitation Services Administration, Social and Rehabilitation Service, Department of Health, Education, and Welfare, Washington, D. C."

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North Carolina Study in Vocational Rehabilitation

Division of Vocational Rehabilitation

Department of Public Instruction

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DAN K. MOORE, Governor

MRS. MARY TRENT SEMANS, Chairman
Governor's Study Committee

THOMAS H. WARD, JR. Vice-Chairman

JOE MORROW, Planning Director

Telephone 682-4902

December 18, 1968

Honorable Dan K. Moore
Governor
State Capitol
Raleigh, North Carolina 27602

Dear Governor Moore:

Herewith your Study Committee on Vocational Rehabilitation, created by your executive order on February 2, 1967, submits its final report for your consideration. This report includes our findings regarding the incidence and prevalence of physical, mental, emotional and social disabilities and the impact that their resulting handicaps have on the total economy of this state; also our impressions of the state's existing rehabilitation resources, their limited capacity in contrast to the state's total need, and the efficacy of these program efforts. Finally, we have included our conclusions and recommendations, the implementation of which we believe will result in the development of a more adequate rehabilitation service system which will have the capacity for serving far greater numbers of handicapped persons in our state more effectively and efficiently.

Serving the State of North Carolina in the interest of developing the most adequate programs possible to meet the needs of the handicapped citizens of our state has been an honor. The committee has not taken its responsibility lightly nor found its task an easy one. We do hope that our work will be of benefit to those in official positions of responsibility for developing and delivering rehabilitation services.

We are pleased to report and acknowledge that this committee has had the help and support of many other North Carolina citizens whose participation in the study of rehabilitation problems was solicited. The numbers of such people prevent a formal acknowledgment of their individual contributions, but later on in the report you will see that this effort is the culmination of the work of many dedicated people.

Again, we hope that this report and the information contained herein are helpful to you, the next administration, the legislature and departments of government with program responsibility. You may be assured that we, the members of the Governor's Study Committee, stand ready to be of any other assistance which you deem necessary.

Devotedly,



Mrs. James H. Semans, Chairman
Governor's Study Committee

JHS/ph



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TABLE OF CONTENTS

	page
LETTER OF TRANSMITTAL	iii
INTRODUCTION	vii
FOREWORD	ix
ACKNOWLEDGMENTS	x
SUMMARIES OF MAJOR RECOMMENDATIONS	xii
I. <i>INTRODUCTION</i>	3
II. <i>THE PLANNING ORGANIZATION</i>	
Members of Governor's Study Committee	7
Members of Regional Advisory Committees	9
Members of Task Forces	14
Members of Subcommittees	23
List of Consultants in:	
Research	25
Organization	26
Goals	26
Techniques	26
Members of Planning Staff	27
III. <i>METHODOLOGIES EMPLOYED BY THE PLANNING PROJECT</i>	
Original Premises of the Study	31
Organizational Procedures and Functions of Organizational Units	32
Organizational Units	
Staff Responsibility	35
Subcontracts	36
Conclusions Regarding Organization and Procedure	36
IV. <i>FINDINGS AND RECOMMENDATIONS</i>	
A Synthesis of a Survey in Durham, Pitt and Transylvania Counties	
Concerning Disabilities	41
Implications of the Population Survey	49
Discussion of Sociocultural Deprivation	56
Maps of Areas Indicating Density of Social and Cultural Deprivation	57
Discussion of Military Rejectees	59
Maps Indicating Incidence and Cause of Military Rejection	60
Single Disability Task Force Reports	
Alcoholic	67
Cerebral Palsy	70
Hearing	71
Heart, Cancer and Stroke	111
Mental Illness	118
Mental Retardation	120
Public Offender	122
Pulmonary	125
Vision	Separate Report

Summary of All Public Hearings	131
Regional Advisory Committee Reports	
Coastal	134
Mountain	136
Piedmont	165
Interagency Relationships Survey	181
Conclusions and Recommendations	196
Sample Survey	197
Summary of Workshop Studies	201
Coordination with Other State Planning Groups	209
Regional Medical Program on Heart, Cancer and Stroke	
Governor's Blue Ribbon Commission on Education	
Council on Mental Retardation	
Mental Health Planning	
Comprehensive Health Planning	
Model Cities	
CAMPS	
Technical Action Panels	
Concentrated Employment Program	
Analysis of State Agency Data and Personal Characteristics and Caseload Practices	215
Report of Counselor Caseload Practice Survey	261
Study of the Administrative Location of the State Vocational Rehabilitation Agency	269
Report to the Governor's Study Committee on the Administrative Location	
of the Vocational Rehabilitation Agency	270
A Report on the Work of the Architectural Barriers Subcommittee of the	
Governor's Study Committee	279
A Report of Efforts to Bring Vocational Rehabilitation to the Attention of	
Candidates for Public Office	283
A Report on Transportation Problems	286
 V. <i>THE COMPOSITE WORKING PLAN</i>	
Total Projected Need of Cost of Needed Services by Disability	289
Plans for the Expansion of Vocational Rehabilitation Services	296
 VI. <i>CONTINUED PLANNING AND FOLLOW-UP</i>	
Organization for Community and Citizen Participation in	
Vocational Rehabilitation Agency Programming	301
Community Resources	302
Description of Boards	305
Structure for Continuation of Planning	308

Introduction

This report represents the efforts of many North Carolina citizens who have for the past two years (January 1, 1967-December 1968) voluntarily addressed themselves to discovering and defining the rehabilitation needs of the disabled handicapped people in our population. The purpose of their endeavor was to make recommendations, on the basis of their findings, for the development of a comprehensive state wide system of rehabilitation programs adequate for coping with the needs of all vocationally handicapped residents within our states borders.

Most of the people recruited to assist in this Study and Planning endeavor were at least vaguely aware of traditional vocational rehabilitation practices and services. They were more acutely aware of the complex problems sometimes imposed by various forms of disability and they were sensitive to the fact that these problems are often inadequately met or in many cases unmet.

For the purpose of this Study, vocational rehabilitation was interpreted to all those who became involved in it as a *civil right* in the broadest sense for handicapped individuals. Emphasis was placed on the idea that vocational rehabilitation was not the sole responsibility of the Vocational Rehabilitation Agency but involved all other social service agencies and institutions. It was upon this base that the participants in the Study were directed to view vocational rehabilitation from a wide perspective that would include not only the needs of persons entering or in the employment age range but also those of pre-school, school children and early youth. This approach was taken because successful vocational rehabilitation is largely dependent upon the services rendered prior to an individual's attainment of the age when vocational planning and preparation become important. It was also felt that through this approach preventive measures might be described and recommended which would preclude the development of vocational rehabilitation needs.

The North Carolina Study in Vocational Rehabilitation was structured in this way largely because of the profound influence of "Humanitation II", a paper presented by Frederick A. Whitehouse, Ph.D. Humanitation, as described by Dr. Whitehouse is a science of human economy and is "*based upon the assumption that we must endeavor to provide every man with the maximum opportunity to live a useful, constructive and happy life: by anticipation of his needs and problems, by making information available to him so that he may make appropriate choices related to his life by freeing him from some of the vagaries of fate which may cause his destruction, and by the constitution of a society and its institutions which would be conducive to his best physical and mental well being*".¹

In the course of the Study, considerable attention has been given to the identification of existing resources and the patterns of their utilization. The characteristics of the population and the services rendered to those with rehabilitation needs have been carefully analyzed. Particular emphasis has been given to determining needed resources that are non-existent within the state and considerable encouragement has been given to the development of better intra and inter-agency communication and increased co-ordination of service efforts have been encouraged. Stress has been placed appropriately on the economics of rehabilitation but the Governor's Committee and its auxiliary groups have been concerned with *improving the quality of life available* to the seriously handicapped.

Although there have been no direct discussions related specifically to the cultural needs of handicapped individuals this is an important area which deserves greater attention in the future. Our state has fortunately made a beginning in providing at least limited cultural exposure for the severely limited insofar as there has been established here an Art Museum for the blind, which has received national recognition.

This museum is being used by other states as a prototype for the establishment of similar institutions. Such developments are receiving national encouragement and we of this state should be grateful to Miss Mary Switzer, Administrator, Social and Rehabilitation Services Administration, Department of Health, Education and Welfare who has been instrumental in promoting our facility. Other efforts in this direction are mandatory if the disabled are to be fully integrated into our culture.

The pages of this document include the *data, findings, recommendations* and *rationale* for developing a full rehabilitation program as perceived by the North Carolina Study in Vocational Rehabilitation. It is hoped that this material can and will be used effectively by all social service agencies and others with responsibility and authority to implement service programs for the disabled.

Foreword

For the past two years the North Carolina Study in Vocational Rehabilitation has engaged in an intensive investigation of the state's disabled population and public and private service programs available to the disabled. The utilization and the effectiveness of service resources have been closely scrutinized and information sought regarding needed resources which are unavailable within the state or certain geographic areas.

This effort has been the primary responsibility of a very small staff with limited financial and technical resources at their disposal. The lack of material resources, however, has been more than offset by the enthusiastic support, guidance, assistance and encouragement of hundreds of North Carolina citizens. The project has also been extremely fortunate in the voluntary cooperation and help provided by the Division of Vocational Rehabilitation and its personnel. Other state and community agencies have also been especially helpful in arranging for meetings and facilities needed for the execution of this planning effort.

Every aspect of rehabilitation that time and money would allow has been examined and analyzed. Conditions requiring rehabilitative services have been discussed at length and there seems to be an overwhelming consensus of opinion that more conditions require rehabilitation attention than those served heretofore by rehabilitation agencies. Agency procedures, practices and administration have all received much attention and it would seem that expanded programs, streamlined procedures, and improved administration is a must if the state is to provide effectively for its people. One outstanding thing that has been learned is that the problem of communication and cooperation between agencies cannot be achieved as easily and simply as having personnel willing and dedicated to doing so; much will be said about this problem in the body of this report.

Any investigation of the type that has been sponsored by the North Carolina Study in Vocational Rehabilitation can be unduly threatening to the personnel in agencies and programs being investigated. It is hoped, however, that this report will not be approached from a defensive position even though it is being constructed to describe program weaknesses, faults, absences and limiting restrictions. The document is not being structured in this way because of any desire to be unduly critical, but so that the agencies and organizations involved in rehabilitation may use it to improve their operations and increase their capacity for serving more of the population in need.

As a result of this study it would be ultimately easier to praise the state and its rehabilitation programs than to define program problems, since the latter approach carries with it the responsibility for offering suggested solutions. Finally, it should be said that the North Carolina Rehabilitation Agency and other agencies and organizations involved in rehabilitation deserve praise and the appreciation of the state for the good work that they have done thus far; however, the state's needs at this time are greater than its ability to meet these needs. Thomas A. Edison is credited with this quote: "There is a better way—find it." This must be the posture of the state regarding vocational rehabilitation if its resources are ever to adequately meet the needs of its handicapped people.

Acknowledgments

In a project like the one being reported it is tremendously difficult to acknowledge the contributions made by everyone who deserves recognition. There have been well over 300 persons actively involved in the state wide comprehensive study and planning activity for Vocational Rehabilitation. There have been many others who made valuable contributions by their encouragement, support and information provided the various study groups. However, there have been numerous people whose help and/or leadership has been so outstanding that they must be given special recognition.

Governor Daniel Killian Moore has been unusually supportive by being so available to hear, carefully consider and provide suggestions for the solution of problems that are bound to occur in the course of a project of this magnitude. Governor Moore's secretary, Mrs. Rachel Spears also should be recognized for her courteous reception and help when contacts were made with the Governor's office. Another person on the Governor's staff whose assistance, cooperativeness and counsel has been invaluable is Mr. Charles Dunn, the Governor's Administrative Assistant.

Special thanks are also due Dr. Charles F. Carroll, State Superintendent of Public Instruction who has always been willing to discuss the activities of the Study and who has given support in each instance when such was needed. Mrs. Jeanne Talbert, the superintendent's secretary has been most helpful in arranging necessary meetings with Dr. Carroll.

The entire Division of Vocational Rehabilitation has been gracious and helpful to the Project. Mr. Claude A. Myer, Director, has been especially helpful and has spent great blocks of time in giving valuable consultation to the Project Director to assure the success of the Project.

Individual recognition is also due Mr. Robert A. Lassiter, former Director of the Division of Vocational Rehabilitation, and presently Director of the Rehabilitation Counselor Training Program at the University of North Carolina at Chapel Hill. The Project was initiated under Mr. Lassiter's direction and his continuous encouragement and support has been a needed inspiration.

Mrs. James H Semans, Chairman of the Governor's Study Committee on Vocational Rehabilitation, has undoubtedly been the driving force behind the Project. Her sensitivity to human needs, her enthusiasm for strengthening programs for the elimination of human suffering and her wisdom in working with others has provided the momentum for the accomplishments of the North Carolina Study.

All of the various Advisory Committees and Task Force Chairmen have done outstanding jobs, but one who deserves special recognition is Mr. R. D. Newnam, who has been an almost constant consultant to the Project Director. During moments of discouragement R. D.'s patience and willingness to listen to problems has been a sustaining force.

There are other individuals whose help with the mechanics of preparing this document should not go unnoticed. Some of these people who have done large quantities of quality work have been Mrs. Frances Foushee of the Department of Sociology and Anthropology, North Carolina State University, Mrs. Brenda Champion, secretary to the Mental Retardation Institute, and Mrs. Marjorie Fleming, Administrative Secretary, Western Carolina Center in Morganton, North Carolina. One other person that deserves a note of special appreciation is Mr. Robert (Bob) Cunningham, a Durham businessman whose voluntary efforts have exceeded his responsibility to keep the Project's office equipment in top working condition; thereby making production within deadlines possible.

It would certainly be a mistake not to acknowledge the contributions of the Project Director's Staff: Mrs. Polly Haugland, Mrs. Donna Wilson, Mrs. Shirley Crowder and Mr. Don Dunson. If it were not for the hours of non-compensated over time spent enthusiastically by these individuals this report and the accomplishments of the Project could not have been completed in the two years of the Project's operation. This staff is one that could not easily be matched for their working compatibility and good nature in spite of demanding responsibilities.

Recognition should also be given Dr. Horace Rawls, North Carolina State University, who served as Research Associate on a part-time basis during the first year of the Study.

Last but not least, it should be recognized that the Project Director's family has been intimately involved in every aspect of the North Carolina Study in Vocational Rehabilitation. These family members have worked countless week ends and evenings with only a little "thanks" and without accruing petty, sick or vacation leave.

It is felt that the state owes a debt of gratitude to these and the hundreds of other people who have made the Study as successful as it has been.

Joe C. Morrow, Planning Director
North Carolina Study in Vocational Rehabilitation

Summary of Recommendations of the North Carolina Study in Vocational Rehabilitation

The following general recommendations are a listing of the steps which it is believed should be taken by the state if the state is to develop a vocational rehabilitation program adequate to meet the needs of its citizenry. The recommendations are listed in priority order and are footnoted to indicate where the reader might find background data and the justification for each recommendation made. The reason for not including background and justification in this summary is to avoid needless repetition. Each of these recommendations have so many ramifications that they cannot be legitimately justified with any degree of brevity.

ADMINISTRATIVE RECOMMENDATIONS

1. It is recommended that the North Carolina Division of Vocational Rehabilitation be allocated sufficient state funds annually to permit the state to match all available matching funds from the Social and Rehabilitation Services Administration of the Department of Health, Education and Welfare. pp. 119, 132, 197, 261, 290.
2. It is recommended that the state take proper steps to create for the Division of Vocational Rehabilitation greater public visibility. pp. 166, 167, 269, 301.
3. It is recommended that the Division of Vocational Rehabilitation upgrade its professional staff by recruiting personnel with professional training, encouraging and supporting full use of educational leave and by developing its own sophisticated in-service training program. pp. 196, 228, 269, 264, 292.
4. It is recommended that the Vocational Rehabilitation Agency take immediate steps to improve its inter and intra agency communication, cooperation and coordination. pp. 131, 135, 174, 196, 198, 224, 238, 243.
5. It is recommended that the Vocational Rehabilitation Agency create standard personnel policies and procedures for employment, promotion and evaluation of agency personnel. It is believed that such action would help eliminate the problem of staff turnover. pp. 138, 264, 296.
6. It is recommended that the Vocational Rehabilitation Agency widen the geographic distribution of its staff so that there will be an office and a resident counselor for every county or combination of counties with a population of 30,000 people. pp. 132, 296, 297, 198.
7. It is recommended that the Vocational Rehabilitation Agency employ more rehabilitation counselors and establish career incentives for these positions. pp. 120, 135, 138, 167, 171, 174.
8. It is recommended that the Vocational Rehabilitation Agency assume greater responsibility for providing technical assistance to community based rehabilitation programs. This would include providing or financing in-service training for personnel in these programs where indicated. pp. 119, 120, 168, 169, 171, 172, 202.
9. It is recommended that the Division of Vocational Rehabilitation establish standards and a licensing procedure with regard to community sheltered workshops and rehabilitation houses from whom they are to purchase rehabilitation services. Such licensing should help to eliminate many of the inconsistent, inadequate and inferior services that the agency is now purchasing, often at the expense of the client. p. 167.
10. It is recommended that the Vocational Rehabilitation Agency, in consultation with all other public and private agencies concerned with the problems of deafness and hearing impairment,

convene a conference for the purpose of establishing a coordinating committee to identify the present programs being provided to persons with hearing impairment, identify service gaps which may exist, and act as a clearing house for the dissemination of information concerning hearing impairment, program developments and joint planning for the rehabilitation of people in this category. 79, 89, 99, 110.

11. It is recommended that the Vocational Rehabilitation Agency investigate methods by which it can be routinely notified of the approval for constructing buildings with public funds. It is further recommended that the agency establish procedures for performing a "watch dog" function to insure that the State Building Code is followed in the construction of new public buildings insofar as architectural barriers are concerned. p. 281.
12. It is recommended that the definition of blindness be modified insofar as the vocational rehabilitation activities of the State Commission for the Blind are concerned. The definition should be modified to insure rehabilitation services to all persons with a diagnosis of 20/100 in the better eye with best correction and/or visual field limitation of 60 per cent. Refer to Vision Task Force Report, p. 8.
13. It is recommended that the Division of Vocational Rehabilitation and the North Carolina Industrial Commission establish a cooperative program that would insure the provision of vocational rehabilitation services to the industrially disabled as quickly as possible following an industrial accident. Joint action by the two agencies involved should insure an increased number of referrals to the Rehabilitation Agency who have the best rehabilitation potential and should also curtail the length of time that persons are unemployed pending the settlement of industrial court cases. See Table 31 on page 238. (There were only 28 referrals from this resource in 1967.) p. 209.
14. It is recommended that the Vocational Rehabilitation Agency employ at least one qualified training officer for each of its geographic areas. These persons would be responsible to the state in-service training supervisor and for the development of a uniform inservice training program to be provided for rehabilitation personnel at the district office level. These persons do not necessarily need to be experts in Vocational Rehabilitation but should have training or experience in the field of adult education and be able to recruit persons with specific professional competence at the local level to give training in the technical aspects of rehabilitation. pp. 264, 296.
15. It is recommended that each district office be enlarged to provide ample space for planned in-service training programs for the total district office professional staff. Such space could also be utilized for group vocational interest and aptitude testing. Reference is made to such group testing in recommendation ten under the heading Case Service Recommendations. p. 265.
16. It is recommended that the agency conduct a comprehensive study of a significant number of the referrals being closed from referral. Such a study should be geared to determining why the referral was made to the agency in the first place, was there any benefit from the referral, did the agency refer its non-accepted cases to more appropriate sources of service and are the people who are not accepted for rehabilitation services making a satisfactory adjustment in their community? pp. 49, 166, 218, 224, 238, 239.
17. It is recommended that the Vocational Rehabilitation Agency be authorized to create numerous advisory groups to assist the agency in planning service programs. It is further recommended that the agency take full advantage of the opportunity to utilize the potential inherent in such citizen advisory groups. pp. 196, 305, 308.
18. It is recommended that the Vocational Rehabilitation Agency conduct a follow-up study on a significant number of military rejectees in order to determine the service program needs represented by this group. p. 63.

19. It is recommended that the Vocational Rehabilitation Agency establish a procedure for paying workshop and facility service fees on a cost accounting basis. This recommendation is realistic only if recommendations eight and nine are implemented. If these previous recommendations are implemented such a method of payment is the only reasonable course of action. pp. 170, 172, 202.
20. It is recommended that the Vocational Rehabilitation Agency initiate more cooperative programs with other agencies and that authority for program design and operation be controlled by a joint committee of representatives of the cooperating agencies. The focus of these committees should be on their particular program rather than their individual agencies traditions. Of course, it is understood that these committees would have to receive the sanction of the sponsoring agencies before taking official action. However, such a mechanism should encourage the use of imaginative programming since the people involved would know that their agencies did not expect them to follow a traditional course. pp. 59, 63, 131, 133, 139, 156.
21. It is recommended that the state create a research branch with responsibility for program evaluation and with responsibility for designing, standardizing and evaluating new techniques of rehabilitation that seem to have promising potential. pp. 135, 138, 139, 167, 168, 308.

CASE SERVICE RECOMMENDATIONS

1. It is recommended that the state establish procedures for much earlier identification of handicapping conditions. pp. 138, 139, 140.
 - Visual Impairment or Loss
 - Hearing Impairment or Loss
 - Learning Disfunctions
 - Mental Retardation
 - Emotional Illness
 - Behavioral Disorders
 - Physical Disabilities
2. It is recommended that the state initiate pre-school and school programs designed to minimize the developmental effects of disability and to develop the disabled individuals' assets to maximum potential. pp. 78, 79, 80, 87, 88, 89. See Vision Task Force Report.
3. It is recommended that more vocational and technical courses be introduced into the curriculum of public schools, pp. 134, 138, 154, Vision Task Force Report.
4. It is recommended that the present social studies curriculum of junior high school level be revised so that it acquaints students with community programs available to him once he is no longer in school. pp. 302, 303, 304.
5. It is recommended that the public school authorities be made more aware of the resources represented by the state's community and technical college system and that more students, particularly those with disabilities, be guided into them. pp. 138, 148, 196.
6. It is recommended that the Vocational Rehabilitation Agency develop more fully its counseling and guidance function. pp. 196, 240, 291, 292.
7. It is recommended that the Vocational Rehabilitation Agency become more aggressive in the areas of case finding, job development, placement and follow-up. pp. 59, 291, 296.
8. It is recommended that the Vocational Rehabilitation Agency evaluate more completely every referral which it receives. The need for more adequate evaluation is especially critical in the area of psychological adjustment. pp. 196, 240, 241, 242, 262.

9. It is recommended that the Vocational Rehabilitation Agency provide more comprehensive service to its physical restoration clients. pp. 196, 221, 240, 241.
10. It is recommended that the Vocational Rehabilitation Agency hire at least twelve persons with baccalaureate or masters degree training in psychology to do group evaluations of characteristics important to vocational choice, preparation and participation. 242.
11. It is recommended that emergency beds be provided in local hospitals to allow for the community care and rehabilitation of persons with alcoholism. See Report of Task Force on Alcoholism. p. 68
12. It is recommended that provisions be made for permanent sheltered living facilities in the communities which have sheltered workshops which can feasibly employ persons who may need such accommodations. See report of Task Force on Mental Retardation pp. 120, 121, 202.
13. It is recommended that the state develop a system of comprehensive rehabilitation centers to rehabilitate the seriously and multiply handicapped physically disabled. See report of Task Force on Heart, Cancer and Stroke, pp. 111, 117.
14. It is recommended that attempts be made to strengthen the relationship between state and county governments insofar as vocational rehabilitation programming is concerned. pp. 305-306.
15. It is recommended that wherever vacant beds occur in the state's tuberculosis sanatorium system that centers be established for the treatment, conditioning and rehabilitation of persons with other pulmonary conditions. It is further suggested that the vocational rehabilitation programs presently provided for in tuberculosis sanatoriums be strengthened so that they will include physical, mental and work tolerance conditioning before a patient is discharged from the sanatorium. Included in this recommendation is the idea that the vocational rehabilitation counselor assigned to the center should be much more active in helping the sanatorium client make a transition from the institution back to the community by helping the individual prepare for or secure employment commensurate with his abilities. After a satisfactory placement is made, some continuous support and follow-up from the vocational rehabilitation counselor should be provided before the person is closed as rehabilitated. See Report of Task Force on Pulmonary Disabilities, pp. 125-127.
16. It is recommended that the State Commission for the Blind initiate steps for the development of additional Industries for the Blind in the portions of North Carolina presently being served by no such facility. It is also recommended that the Commission help the presently established and operating Industries for the Blind to develop within their operations an evaluation and training component geared for providing services to transitional clients who with proper counseling, guidance, training and work experiences may find satisfactory employment in the competitive labor market. See Report of Visual Task Force, p. 10.
17. It is recommended that the Vocational Rehabilitation Agency expand its services for the aged, specifically in those areas where the agency has the most competence; that is vocational training, vocational rehabilitation counseling, vocational evaluation, sheltered workshop placement and selective job placement. pp. 133, 174.
18. It is recommended that the Vocational Rehabilitation Agency employ a rehabilitation house specialist whose duties would include working with communities in which rehabilitation houses have already been established and in communities which are in the process of establishing rehabilitation houses. His function should include working with community boards, state agencies and institutions. Also, he should be able to enlist the help and support of local physicians and psychiatrists. He would serve as a resource person for house parents and other professional personnel working in the area of behavioral services. pp. 168, 169, 170, 171, 177.
19. It is recommended that the Vocational Rehabilitation Agency employ at the state level, a specialist in workshop development and administration. His functions should be to help establish

standards and standard procedures for workshop services. It would be his responsibility to assist workshops in the acquisition of appropriate equipment, supplies, etc. Also, he should be able to offer technical assistance in setting up bookkeeping systems, the acquisition of subcontracts, the development of vocational evaluation systems and techniques and the development and functions of local workshop boards. pp. 170, 171, 202.

20. It is recommended that the state provide funds to either the Department of Public Health or the Division of Special Education to purchase mobile screening units for the early detection of both visual and hearing impairments. Enough of these units need to be made operational so that all pre-school children in the state can be evaluated before entering grade one. See Report of Hearing Task Force p. 71—Visual Task Force Report p. 11.
21. It is recommended that the state provide for the creation of local coordination councils whose responsibility would be the full integration of all social service efforts and agency functions at the local level to insure the maximum degree of efficiency possible. It is further suggested that these local councils have a very concrete operation rather than being groups that deal primarily with generalities. A method of accomplishing this recommendation would be the discussion of live cases representing problems with which a particular agency cannot cope adequately. pp. 135, 167, 305.
22. It is recommended that the community sheltered workshops in the state be encouraged to expand their orientation so that they can provide meaningful and effective services to disabled groups other than the mentally retarded. The intent of this recommendation is not to imply a curtailment of workshop services to the mentally retarded. Services for this group need to be expanded but sheltered workshops also have considerable potential for serving other groups such as the mentally ill, the individual with behavioral disorders, the hearing impaired and others who are presently receiving few such services. pp. 174, 203. See Report of Mental Health Task Force p. 118. See Report of Public Offender Task Force p. 122. See Report of Pulmonary Task Force p. 125.
23. It is recommended that the Vocational Rehabilitation Agency emphasize and strengthen its outreach function. pp. 59, 63, 301, 306.
24. It is recommended that in areas of the state plagued by transportation problems which have an exaggerated effect on our handicapped population, provision be made for the development of diagnostic centers in which a client could receive full medical, psychological and vocational diagnosis as the result of making one trip as opposed to the possibility of having to make numerous excursions from his isolated community to receive all the diagnostic services necessary to establish eligibility for service and/or the basis for a vocational rehabilitation plan. pp. 132, 286.

Chapter I

Introduction

Chapter I

The preceding summary of recommendations for the development of a Comprehensive State Vocational Rehabilitation Program is a result of a Comprehensive Planning Program which was started January 1, 1967.

The 89th Congress on November 8, 1965 enacted Public Law 89-333 which amended the Vocational Rehabilitation Act. Included in this legislation was provision for each of the various states to conduct comprehensive planning programs so that by 1975, at the latest, all of the states' disabled handicapped populations may have available necessary vocational rehabilitation services. The ultimate goal is to reduce to a bare minimum the amount of dependency in the adult population of each state.

Consequent to the above-mentioned legislation, Secretary of Health, Education, and Welfare, John Gardner, wrote to Governor Dan K. Moore inviting North Carolina to take advantage of the legislative provision for planning, and requesting the governor to designate an appropriate state agency to assume responsibility for the project. The Division of Vocational Rehabilitation, in anticipation of Secretary Gardner's letter, requested the Governor to designate their agency as responsible for Comprehensive Statewide Planning for Rehabilitation Services. Governor Moore complied with this request, stipulating that the planning activity be closely coordinated with the Governor's State Planning Task Force.

Upon designation from the Governor as the agency responsible for Statewide Comprehensive Planning in Vocational Rehabilitation, the Division through its parent agency, the Department of Public Instruction, made application to what was then the Vocational Rehabilitation Administration of the Department of Health, Education, and Welfare for funds with which to initiate a planning project. The project application, which was approved by the Vocational Rehabilitation Administration, specified that the planning program would be concerned with the following general objectives:

1. To identify by number and category those disabled within the state who are in need of vocational rehabilitation services.
2. To prepare a written plan which will identify, analyze, and evaluate program goals, the staff and financial support needed to achieve these goals, with full geographic coverage of all programs offering vocational rehabilitation services.
3. To determine the need for facilities and workshops for the disabled.
4. To identify the barriers that prevent or delay vocational rehabilitation services for the handicapped.
5. To identify vocational rehabilitation resources required to meet future needs, including necessary legislative action, community support, and cost and steps required to facilitate the achievement of statewide goals among the governmental and voluntary programs at state and local levels.
6. To determine ways in which governmental and voluntary programs may be coordinated and reorganized, if necessary, in developing services to more effectively meet the demonstrated needs.

Early in the process of planning two other specific objectives were added to the list previously enumerated. They are as follows:

7. To determine which aspects of rehabilitation programs have the greatest intrinsic value for clients, and whether there are other aspects that have only assumed value.
8. To explore the professional and attitudinal characteristics of the professional staff of the Vocational Rehabilitation Agency.

Determination was also made that the planning program should be given a very *broad scope*. This decision was made because of the rapid transitions occurring in today's society and because it was felt that current rehabilitation legislation should, and probably would, be interpreted broadly, thereby increasing the numbers and kinds of programs involving the Vocational Rehabilitation Agency. Another basic premise upon which planning in North Carolina was based is that almost every service program sponsored by state, local and federal governments has a rehabilitative component. Most agencies share responsibilities for rehabilitation and are differentiated primarily by their emphasis. Clients are served by the agency with primary responsibility for their most pressing (not only) problem; therefore, the need to be flexible and develop an awareness of, and an appreciation for, all human problems and varying approaches which may have at one time seemed alien to the vocational rehabilitation concept of individual independence seemed important. Problems of poverty, aging, social and cultural deviance, poor education and prejudice needed to be assessed to determine their relationship to the Vocational Rehabilitation Agency and its activities.

Since rehabilitation planning in North Carolina was to encompass such a large scope, it was deemed necessary to seek and secure the involvement of many lay and professional community leaders and as many social agencies as possible. In addition to utilizing community groups to study the state's rehabilitation needs, some fairly pure practical research, carefully designed and conducted by competent people on the project staff, has been completed. Valuable technical help in research has been secured from the Department of Sociology and Anthropology at North Carolina State University and from Greenleigh Associates, a New York research firm which has done a subcontract study of the *organizational and administrative structure* of the North Carolina Division of Vocational Rehabilitation.

Chapter II

Organizational Structure of the North Carolina Study in Vocational Rehabilitation

Chapter II

The North Carolina Division of Vocational Rehabilitation, Department of Public Instruction, is the agency designated responsible for conducting Statewide Comprehensive Planning for Vocational Rehabilitation. The agency, wisely it is thought, decided to limit its role in the project to the fiscal administration of the program. Program responsibility and responsibility for directing the study was given to a committee which the Agency requested the governor to appoint. On February 2, 1967, Governor Dan K. Moore, by executive order, created the *Governor's Study Committee on Vocational Rehabilitation*. To this committee the Governor appointed representatives of the State Legislature, organized labor, the State Planning Task Force, public education, higher education, private rehabilitation agencies, medicine, business, the disabled and other interested citizens. Governor Moore charged his thirty-member committee with the following functions.

- (1) To assist the staff of the North Carolina Study in creating an organization for carefully studying the efficiency of present service programs as they are related to rehabilitation needs existing in North Carolina.
- (2) To review pertinent data collected and presented to the committee by the staff of the North Carolina Vocational Rehabilitation Division.
- (3) To make recommendations for improvement and expansion of service programs so that the disabled within the State of North Carolina may have available resources needed for their rehabilitation.
- (4) To report periodically to the Governor of North Carolina on findings and progress of the Study.
- (5) To prepare, in consultation with and through the facilities of the North Carolina Study in Vocational Rehabilitation, a final report for general distribution throughout the state regarding the rehabilitation needs and program.
- (6) To make recommendations for the development of the most adequate program possible.
- (7) To assist the Governor's office, the Legislature and the state and private agencies in the implementation of recommendations coming from the committee.

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The Governor's Study Committee asked for assistance in meeting their responsibility from a Statewide Advisory Committee composed of the administrators from the following agencies:

The Department of Administration,
State Planning Task Force

The N. C. Commission for the Blind
N. C. Employment Security Commission

The N. C. Good Neighbor Council

The Governor's Committee on Employment of
the Handicapped

The Governor Morehead School (Blind)

The N. C. State Board of Public Health

The N. C. State Industrial Commission

The N. C. Board of Juvenile Corrections

The N. C. Department of Labor

The N. C. Department of Mental Health

The N. C. Fund (State poverty program)

The N. C. Veterans Commission

The N. C. Department of Public Instruction
(Division of Vocational Rehabilitation)

The N. C. Department of Corrections

The N. C. Department of Public Instruction
(Division of Special Education)

The N. C. Department of Public Welfare

The N. C. Recreation Commission

The N. C. School for the Deaf

The N. C. Medical Care Commission

The N. C. Governor's Council on the Aging

It was felt that a state technical advisory committee composed of the heads of the above-named agencies would offer invaluable service insofar as helping to define and identify rehabilitation needs in the State. Other supportive groups were *three regional advisory committees* whose function it was to examine and describe the rehabilitation needs peculiar to their particular geographic areas of the State. These committees are as follows:

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More specialized committees were appointed to study the needs of specific disability groups and make recommendations regarding ways in which the state could consolidate or expand its programs to provide adequate rehabilitation services to persons with specific disabling conditions. These groups were called *Single Disability Task Forces* and they are as follows:

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It was felt that there should be a group who would focus their attention on specific subjects related to the development of the state's vocational rehabilitation program; therefore, the Governor's Study Committee divided itself into various subcommittees. These subcommittees were all chaired by a member of the Governor's Study Committee and consisted of other members of the committee plus non-members from the state with particular knowledge and expertise concerning the particular subject of each subcommittee. The following is a list of the subcommittees of the Governor's Study Committee. The names of members of these subcommittees who are not official members of the Governor's Study Committee have been asterisked.

1. MANPOWER AND TRAINING

Mr. Harry W. Clarke, Chairman

Mr. Bert R. Titus

°Mr. Bill Waters

°Mr. J. J. Beale

°George S. Baroff, Ph.D.

°Mr. Robert A. Lassiter

°Mr. Claude Caldwell

°Mr. Frank Turner

°Mr. Robert Andrews

°Mr. H. E. Springer

°Gilbert Ragland, Ph.D.

°Dr. Granville Tolley

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Supervisor, Staff Training Division of Vocational
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Director, Mental Retardation Training Institute

Planning Director, Rehabilitation
Counselor Training Program,
University of North Carolina

Director, Personnel Department

Personnel Department

Board of Education

Assistant Director, Administrative Services
Division of Vocational Rehabilitation

Professor, Department of Special Education
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2. REHABILITATION WORKSHOPS AND FACILITIES

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Erle Peacock, Jr., M.D.

Mr. H. C. Bradshaw

Bruce H. Dorman, M.D.

°Mr. E. R. Keener

°Mr. Robert L. Denny

°Mr. Deryl Torbert

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Consultant, Social Work, Mental Retardation
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°Mr. Howard Earp	Coordinator, Sheltered Workshop Programs Division of Vocational Rehabilitation
°Mr. Pete Rice	Executive Director, Exchange Club Sheltered Workshop
°Mr. Britt Green	Supervisor, N. C. Commission for the Blind
°Donald Weir, M.D.	School of Medicine, University of North Carolina
°Mr. Barnett Grodsky	Businessman, Board of Directors, Goodwill Industries
°Mr. Charles Schuch	Wake County Cerebral Palsy and Rehabilitation Center

3. REHABILITATION RESOURCES AND INTERAGENCY RELATIONSHIPS

Senator Martha W. Evans, Chairman

Mr. Henry W. Kendall (Deceased)

°Mrs. Ruth Relos	Coordinator Vocational Rehabilitation Services, North Carolina Dept. of Mental Health
°Mr. Bob Harrison	Assistant Director, Program Development Division of Vocational Rehabilitation
°Miss Dorothy Kiester	Specialist in Community Development, Institute of Government
°Mr. James Massenburg	Executive Director, Governor's Committee on Employment of the Handicapped
°James Stone, Ph.D.	Coordinator, State Planning Task Force
°Mr. Clyde Myers	Counselor, Division of Vocational Rehabilitation
°Maylene Irons, M.D.	Private Physician

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Mr. Howard F. Twiggs

°L. L. Schurter, M.D.	State Medical Consultant, Division of Vocational Rehabilitation
°Mr. Marse Grant	Editor, <i>The Biblical Recorder</i> , State Baptist Convention
°Mr. L. K. Parker	Supervisor of Casework, Division of Vocational Rehabilitation
°Thomas Stein, Ph.D.	Professor, Recreation Curriculum, University of North Carolina
°Mr. Robert Urie	Vocational Rehabilitation Administration, Project Director, St. Andrew's College
Mr. Leslie Boney	

5. FINANCES AND LEGISLATION

Mr. Robert Lee Humber, Chairman

Mr. C. W. Phillips

Senator Ralph Scott

Senator Herman Moore

Senator Hargrove Bowles

Mr. W. M. Barbee

°Mr. A. A. Chiemiego	State Supervisor, In-service Training, Division of Vocational Rehabilitation
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°Mr. T. M. Wilson

°Mr. Claude Myer

°Mr. Bill Creech

Lt. Governor

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Assistant Director, Rehabilitation Services
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6. COMMUNICATIONS AND PUBLIC RELATIONS

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Mr. Rudolph Gumpert

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Facial Prosthesis

In addition to the voluntary work done by the committees previously described, the North Carolina Study in Vocational Rehabilitation has added considerable strength to its activities by subcontracting two aspects of the comprehensive planning program. (1) A subcontract was let to North Carolina State University, the Department of Sociology and Anthropology. The department assigned Mr. Vaughn Grisham as full-time director of the subcontracted population survey to determine the incidence and prevalence of disability in North Carolina. It is felt that the University's Department of Sociology and Anthropology, Mr. Grisham, and the interviewing staff which he hired for the project did a thorough and very impressive investigation regarding the problems of disability in the state's general population. A summary of this report is included elsewhere in this volume and the complete report has been published as a separate document and is available for reference.¹

The North Carolina Study in Vocational Rehabilitation subcontracted with Greenleigh Associates, a private research and consultant firm of New York City, to do an organizational and administrative study of the state. Because the agency was in a period of transition and also because there has been much public sentiment suggesting the need for an administrative and organizational investigation to look for solutions to current problems, it was decided that it was crucial to have an out-of-state group conduct this aspect of the study. Their report is published in a separate volume and is available for reference.²

North Carolina has long had a notable system of health, education and welfare programs and has a tradition of showing a great deal of interest in and emphasis on social and health research in its colleges and universities. The state has been fortunate in that the North Carolina Study in Vocational Rehabilitation has been able to secure, gratis in most instances, a great deal of consultative help from many people in the designated subject areas:

1. Research

Francis McConnell, Ph.D., Department of Preventive Medicine, School of Public Health, University of North Carolina, Chapel Hill, N. C. Dr. McConnell was instrumental in doing a major study of neurological diseases. Consultation was in the area of design for citizen involvement while collecting hard data.

¹A Report of a Survey in Durham, Pitt and Transylvania Counties Concerning Disabilities, conducted by Vaughn L. Grisham. Available from the N. C. Department of Vocational Rehabilitation and N. C. Commission for the Blind.

²Administrative and Organizational Study Report. Greenleigh Associates, Inc. Available from the Division of Vocational Rehabilitation, Raleigh, N. C.

Selz C. Mayo, Ph.D., Head, Department of Sociology and Anthropology, North Carolina State University. Dr. Mayo gave us a considerable amount of consultation on the survey and also on the general approaches that the North Carolina Study should take in the research field.

F. E. McVay, Ph.D., Professor of Experimental Statistics, North Carolina State University. Dr. McVay gave us a considerable amount of advice on the selection of counties for the survey and on the sampling technique to be employed within these counties. Bill J. Stines, Associate Statistician in Experimental Statistics, North Carolina State University. Mr. Stines not only gave us consultation on techniques in arriving at our sample, but actually did some of the preliminary work in setting up the sample for the household survey.

Lacoe Alltop, Statistical Division of the North Carolina Department of Mental Health. He discussed with us at some length the way in which various statistics concerning mental health could be obtained and showed Mrs. Crowder equipment he has for running off some of this data and offered to do some of it for us.

Robert Rollins, M.D., Superintendent, Dorothea Dix Hospital, Raleigh. Dr. Rollins gave us consultation concerning the mental health area and problems he feels should be investigated. He has also supplied us with office space in Dorothea Dix Hospital so we can carry on our work in the Raleigh area.

2. Organization

George Baroff, Ph.D. Dr. Baroff has given valuable advice regarding community organization necessary for effectively carrying out activity programs.

Mr. Robert Lassiter, Director, Rehabilitation Counselor Training Program, School of Education, U.N.C. From Mr. Lassiter's experience with professional and volunteer groups, we have been able to profit a great deal.

Mr. Frank Moore, Department of Psychology, University of Oklahoma. Mr. Moore was director of the Legislative study council in Oklahoma for two years and has furnished us with a great deal of information resulting from this and other work experience involving social investigations and planning for programs distributed over a wide geographic area.

Mr. Bob Pickard, Social Researcher with the Research section of the School of Sociology, U.N.C., and Mr. Bob Denny, Executive Director North Carolina Council on Mental Retardation, have given valuable general consultation regarding the over-all organizational structure of our state.

3. Goals

Harvey Smith, Ph.D., Director, Research Division, School of Sociology, University of North Carolina

Samuel Cornwell, M.D., Assistant State Director, Department of Mental Health

Marc Musser, M.D., Director, Regional Medical Program, Heart, Cancer and Stroke

Robert Ward, ACSW, Coordinator, State Planning Task Force

Jacob Kooman, Director, North Carolina Department of Public Health

James Stone, Coordinator, State Planning Task Force

Milton Bluc, Ph.D., Director, Special Education, Appalachian University

Mr. R. D. Newman, Assistant Director, Mental Retardation Training Institute

Issac M. Taylor, M.D., Dean of Medical School, U.N.C.

These people have all been contacted and consulted frequently and extensively regarding appropriate goals for the planning project. Their assistance has been invaluable, and their varied backgrounds and interests have given us a broad perspective of our responsibility.

4. Techniques

Ranjit Majumder, Ph.D., Research Associate, West Virginia Statewide Planning Project

Mr. Ray Power, Director, West Virginia Statewide Planning Project

W. P. Richardson, M.D., School of Medicine, U.N.C.

Mr. George Clark, Director, New Mexico Statewide Planning Project

Mr. H. Parker Evatt, Executive Director, The Alston Wilkes Society, Columbia, South Carolina

Mr. Berton Fliegel, Director, Community Planning for Vocational Rehabilitation Planning Commission, Newton Center, Massachusetts

These people have spent generous amounts of time with us, discussing techniques with which they have had experience while doing very similar kinds of studies.

The planning project has been very fortunate in the stability of its paid staff, with only one professional staff member having resigned from the project before its conclusion. All other staff members have worked consistently since the time of their employment to help plan a rehabilitation program for the State. The following is a list of project personnel:

Mr. Joe Morrow	Planning Director
Mr. Donald Dunson	Community Research Coordinator
Mrs. Shirley D. Crowder	Social Research Assistant
Mrs. Polly Haugland	Administrative Secretary
Mrs. Donna B. Wilson	Secretary
Horace Rawls, Ph.D. Research Associate (part-time), terminated employment in May, 1968.	

Chapter III

Methodologies Employed by the Planning Project

Original Premises of the Study

The methodological approach to Comprehensive Statewide Planning and Study of Vocational Rehabilitation Programs could not adequately be determined until the objectives of the program were well concretized. Consequent to a great deal of thought and consideration on the part of the project's director, in consultation with the state directors of the Vocational Rehabilitation Agency, Commission for the Blind, and other professional persons interested in the development of a comprehensive rehabilitation program for the state, there were developed three basic premises which ultimately determined the procedures utilized in accomplishing the purposes of the planning program.

These premises are:

(1) Vocational rehabilitation should be viewed from the broadest possible scope. The necessity for doing this came from the realization that vocational rehabilitation potential is ultimately dependent on other services which are provided to the disabled before specific vocational rehabilitation or habilitation services are initiated. For example, the vocational rehabilitation potential of a person handicapped from childhood is directly dependent upon the developmental experiences during childhood, the public education available to the individual, and the attitudes that the individual develops through contacts with his school, community and family regarding his condition. The same is true for the person who suffers disability resulting from disease or trauma later in life. His potential is directly dependent on the attitudes which he has developed concerning himself, disability, vocational independence, etc., from his contacts with his environment. This person's adjustment to disability and his ability to overcome a resulting handicap is in reality directly related to his adjustment before becoming disabled.

Another consideration was that vocational adjustment is directly dependent upon personal adjustment in other areas. It seems to be non-feasible to expect vocational rehabilitation efforts to be effective unless other services are provided at the same time which would make it possible for the disabled individual to establish a satisfactory adjustment in his total life pattern. If the disabled individual's feelings about himself, the social institutions in his environment, and his relationship to his family are ignored, his feelings and situational involvements will probably become so disruptive that his vocational adjustment will be jeopardized no matter how much employment skill he possesses.

For these above-mentioned reasons, it was decided that the North Carolina Study in Vocational Rehabilitation could not realistically plan for the development of an effective rehabilitation system that would materially affect and improve the lives of the state's disabled people unless it embraced and made itself available to all social agencies who, after all, have either direct or indirect responsibility for helping disabled handicapped and/or disadvantaged individuals attain a vocational adjustment, if such is within the realm of their capacity. In an attempt to place the North Carolina Study in Vocational Rehabilitation in a proper position, so far as other agencies were concerned, it was decided that the study operation should be separated from the Vocational Rehabilitation Agency's service and administrative operations and that an attempt be made to establish an individual identity which would enhance the possibilities of the study having substantive involvements with other state and local agencies and organizations.

2. The second major premise which influenced the methods utilized in the study was that a complete study and comprehensive plan for an adequate state vocational rehabilitation program could be completed fairly rapidly and simply by veterans of vocational rehabilitation programs. To utilize such a course of action, however, was determined to be unwise since it would inevitably result in a

report and in recommendations that were biased by traditional practices and concepts of the Vocational Rehabilitation Agency.

For the Statewide Comprehensive Study to be of any intrinsic value, it was felt imperative to conduct the study without the shackles of tradition. This belief was developed, not because tradition should be condemned, but because the state and its organized effort in rehabilitation needed to have its perspectives broadened if objective evidence indicated that there were problems being overlooked. Also use of veteran vocational rehabilitation professionals to study and make recommendations for an expanded program would give the agency no base of support for implementing the recommendations.

It is traditional that agency personnel have requested more program expansion than state legislative bodies have supported. Recognizing that state legislatures receive much pressure from many different areas and requests that far outstrip available resources, it is understandable that the support which they give programs is never in the amount requested, but it was also felt that a factor which limits support is that budgets are usually solicited by people who have an "ax to grind" and who have a specific interest in receiving increased support.

3. On the basis of the first two premises, the concluding premise upon which the North Carolina Study in Vocational Rehabilitation was based was that citizen involvement in the study of rehabilitation needs, programs and the desirability for expanding rehabilitation services was mandatory. With broad citizen involvement it was expected that the study would achieve a degree of objectivity otherwise impossible. It was also felt that if a sufficient number of citizens (lay, public and private) were involved in looking at the problems of disability and the programs presently provided by public and private resources, they could lend to the professionals a broadened perspective regarding needs hitherto unrecognized, and by being free from tradition they could suggest previously untried approaches to the amelioration of rehabilitation problems.

It was with a great deal of certainty that the study of rehabilitation needs was approached from the position that service programs now available are inadequate to meet the needs of the state's handicapped population. It was supposed that through a citizen study, the inadequacies of the vocational rehabilitation program could be defined and the economic and social legitimacy of the vocational rehabilitation effort established, thereby creating a popular demand for the implementation of more favorable rehabilitation programs.

Organizational Procedures and Functions of Organizational Units

On the basis of the above-enumerated premise that citizen involvement in the planning project was a must, the first activity of the North Carolina Study in Vocational Rehabilitation was to secure a citizen's committee appointed by the Governor which would well represent the state geographically and professionally, in accordance with special interests, and be representative of the disabled themselves for whom a better vocational rehabilitation system was to be developed.

The state was fortunate in having a citizen widely known and respected who had shown through previous activities and involvement a continuing concern for programs in behalf of disabled handicapped and disadvantaged citizens. This person already had an identity with the Vocational Rehabilitation Agency because of her loyal support of the agency's program and her many previous contacts with the Agency. This individual was already a member of the National Citizen's Advisory Committee on Vocational Rehabilitation appointed by the Secretary of Health, Education and Welfare. In addition to *Mrs. Mary D.B.T. Semans'* affiliation with the Vocational Rehabilitation Movement, she was well known and respected by the Governor of North Carolina who had called upon her to serve the state in other capacities. Therefore, Mrs. Semans was a natural choice of the Governor, the Vocational Rehabilitation Agency and the Commission for the Blind to be chairman of the GOVERNOR'S STUDY COMMITTEE ON VOCATIONAL REHABILITATION.

In consultation with Mrs. Semans, the directors of the Vocational Rehabilitation Agency and the Commission for the Blind and other administrative staff members of the Vocational Rehabilitation Agency, a list of prominent North Carolina citizens who had shown interest in services to the disabled was compiled and submitted to the Governor to be considered for appointment to the Governor's

Study Committee. Governor Moore, in his wisdom, issued invitations to all the people who had been suggested for membership and added several members who, of his own knowledge, were interested in the betterment of the state's rehabilitation system. The result was that the North Carolina Study in Vocational Rehabilitation has a larger executive committee than had originally been anticipated since it was felt that the Governor probably would choose to appoint only one person from each "walk of life" who had been suggested. It was indeed fortunate, however, that Governor Moore had the foresight of knowing that the study should have a relatively large board since all the members of the board were extremely busy people and would find it difficult to convene simultaneously for activities. As a result of the larger than expected committee, however, we have been able to have adequate representation for all of the committee's functions.

After the appointment of the Governor's Study Committee, the committee divided itself into subcommittees which were to address themselves to particularly pertinent administrative and functional problems related to the fullest development of the state's rehabilitation resources. Although the committee was relatively large, as has been previously mentioned, it was not large enough to have adequate representation for each of its subcommittees; therefore, a decision was made to invite other professional people from the state who had particular expertise in the subcommittee's problem area. Each subcommittee was chaired by an official member who had been appointed by the Governor.

The subcommittees previously enumerated and described in Chapter II of this report were charged with specific responsibilities for finding solutions to particular problems faced by state and private rehabilitation resources. Unfortunately, logistics and the busy schedules of persons appointed to these subcommittees prevented the subcommittees from functioning very effectively. In fact, most of the subcommittees have had only one meeting.

The problem areas were not sufficiently clarified to allow these groups to take any concrete action or even submit proposals with substance for implementation. The one real exception was the subcommittee on *Architectural Barriers* which was very active and instrumental in securing changes in the State Building Code so that North Carolina's Building Code now complies with the nationally accepted standards. Also, there was received a report on problems of *public relations* and *communications* that has provided valuable leads regarding the development of an adequate communication and public relations program for the Rehabilitation Agency.

The inactivity of the subcommittees of the Governor's Study Committee can largely be attributed to the staff of the North Carolina Study in Vocational Rehabilitation making inadequate preparations to define for the subcommittees the intricacies of the problems with which they were being asked to deal. Also, the size of the staff and its many other activities did not provide adequate leadership and stimulation to enable the committees to be very active.

Because North Carolina is a large state and has three distinct geographic areas manifesting distinctly different rehabilitation problems, three regional advisory committees were formed. These committees were to define and describe rehabilitation problems peculiar to their particular demographic locations. These committees were asked to survey their particular regions in regard to the rehabilitation resources available and unavailable in their particular areas of the state. The most concrete function suggested to the Regional Advisory Committees and ultimately completed very satisfactorily was the conduct of public hearings. Each area committee heard from a broad segment of the community regarding rehabilitation needs at the local level, as interpreted by community people. In all, the three Regional Citizen's Advisory Committees conducted eleven public hearings which provided both the committee and the staff of the North Carolina Study in Vocational Rehabilitation tremendous amounts of valuable material that has proved very helpful in identifying the state's rehabilitation needs and in planning programs to meet these needs. The regional advisory committees held their public hearings in such locations as to provide a good sample of the total area represented by the committee. Testimony received in all of the hearings was by and large complementary and showed a great amount of commonality¹ of problems in all parts of the state; however, distinct differences were identified. The content of the various hearings will be discussed in more detail in Chapter IV. The hearings were attended by representatives of all local social agencies which could be identified. There was a great deal of newspaper, radio, and television publicity regarding the hearings, in which a special appeal was

¹See page 131 for summary.

made for individual citizen involvement. The disabled and needy did not respond to these invitations as had been anticipated and hoped for but when and where they did appear as witnesses, their testimonies were invaluable.

The Regional Advisory Committees are responsible for reporting their findings, suggestions and recommendations regarding program development directly to the Governor's Study Committee. Such reports have been made and members of the Regional Advisory Committees are anticipating that their respective regions will feel some positive effects of any support that their reports might get from the Governor's Study Committee.

There were some difficulties in the functioning of the Regional Advisory Committees that are basically the same, but to a lesser degree than those experienced by the subcommittees of the Governor's Study Committee. The regions as formulated were so large that logistical problems did occur and so wide-spread that the limited number of staff members of the North Carolina Study often could not provide as much leadership as would have been desirable. The responsibility and the interest created by the public hearings did a great deal in insuring the success of the Regional Citizen's Advisory Committees.

The members of the Regional Citizen's Advisory Committees were invited to serve on these committees by the Governor's Study Committee on Vocational Rehabilitation. Suggested names were given to the Governor's Study Committee by the staff of the North Carolina Study in Vocational Rehabilitation who had secured a list of potential members by consulting with the Vocational Rehabilitation Agency's area directors, district supervisors and field staff.

It is of significance that very few people who were invited to participate declined the invitation. The staff of the Rehabilitation Agency is to be complimented on the suggestions they made regarding membership in that their suggestions included influential members of their communities, but were not limited to individuals who knew a great deal about the Vocational Rehabilitation Agency or who were particularly supportive of the agency. After the original meetings of the Regional Advisory Committees, committee members themselves suggested other people from their areas whose help they thought would be valuable to the committee. These people were subsequently issued invitations by the Governor's Study Committee to serve and have been invaluable members.

Other organizational units of the North Carolina Study in Vocational Rehabilitation have been eleven *single disability task forces*. The original idea for the task forces was that each should be made up of a multidisciplinary group of professional people who could act similar to a professional rehabilitation staffing team. The original proposal was that the task forces would be oriented to the functions assigned to them and each individual member, armed with this information, would go back to his home community and discuss the task force functions with other people with whom he or she worked daily. After discussing the functions of the task force with associated professionals, the task force would reconvene and attempt to describe the state's system of resources available to the groups whom they represented, and describe an ideal system for meeting the rehabilitation needs of North Carolina. They would recommend how present programs could be "beefed up" and expanded to ideal proportions.

The approach taken to organizing these groups was for the staff of the North Carolina Study to discuss its plan with various disability associations incorporated in the state and request these associations to jointly sponsor a task force. The associations approached with this proposal were the North Carolina Association for Retarded Children, the Mental Health Association, the Association for Crippled Children and Adults, the Cerebral Palsy Association, the Speech and Hearing Association, the Federation for the Blind, the Association for the Blind, and the Tuberculosis and Pulmonary Diseases Association. For persons falling in disability categories not represented by an association, individuals and groups most active in their behalf were approached with this same proposal. Such groups represented epilepsy, the aged, public offenders and alcoholics. Since the North Carolina Regional Medical Program on Heart, Cancer and Stroke already had a Subcommittee on Rehabilitation, contact was made with that group and arrangements were worked out so that their committee could serve both the Regional Medical Program and the North Carolina Study in Vocational Rehabilitation.

Although most of the Single Disability Task Forces have been extremely active and have done excellent work, their activities have not followed the originally prescribed pattern. Reports of the various task forces will be included in Chapter IV.

Unfortunately there have been a number of disabilities whose proposed task force never materialized. These are the Task Force on Orthopedic Disabilities, the Task Force on Epilepsy and the Task Force on Aging. It is felt that the Epilepsy Task Force failed to become a reality either because there is no organization in the state active in behalf of persons with epilepsy or because the association is so loosely organized that the efforts of the North Carolina Study in Vocational Rehabilitation failed to be disseminated. The failure of the Orthopedic Task Force to materialize is not understood unless orthopedics represent such a broad category of disability that rehabilitation and orthopedic impairment are both too nebulous for a group to become viscerally involved. It is felt that the Task Force on Aging had difficulty relating the problems of aging to the traditional concepts of vocational rehabilitation so that this group could never formalize itself. Fortunately, rehabilitation and problems of the aged were discussed at length in two public hearings and recent information published by the Department of Rehabilitation and Special Education, Northeastern University, Boston, Massachusetts will make it possible for us to include this category in our findings and recommendations in Chapter IV.

Staff Responsibility

As has been mentioned in several places above and enumerated on page 27 of Chapter II, the staff of the North Carolina Study in Vocational Rehabilitation was quite small in number. It has been a dedicated staff that has placed itself in precarious positions, not because of its desire to be critical, antagonistic, or troublesome to the Rehabilitation Agency or any other organized effort providing service to the disabled in the state; however, it was necessary to be completely candid regarding findings. There has been real concern on the part of the staff, however, that reports should be completely objective, discussions candid, and poor organization and/or effort and coordination defined and examined for the purpose of improving programs which exist. The responsibility of the staff has been in the following areas and in priority order of the activities mentioned:

1. To organize the state for comprehensive study and planning of rehabilitation programs and needs
2. To develop orientational materials for all of the volunteer groups participating in the planning program
3. To coordinate the activities of the various groups in the study
4. To report to the groups, the Department of Administration, the Vocational Rehabilitation Agency and the Commission for the Blind its findings and the findings of other groups participating in the study
5. Staff research. Research activities have included:
 - A. A study of vocational rehabilitation counselor caseload practices and their awareness of resources
 - B. An analysis of the characteristics of vocational rehabilitation personnel
 - C. An analysis of state agency data by region, district and county
 - D. An analysis of the disabilities served by the Vocational Rehabilitation Agency
 - E. An analysis of closures by geographic location in the state
 - F. A study of cases receiving out-of-state rehabilitation center services
 - G. A 16-county interagency survey
 - H. A report to political candidates during state primary campaigns
 - I. A study of the news coverage and public communication for the Division of Vocational Rehabilitation

All of the above-mentioned research activities will be reported in Chapter IV under Recommendations and Findings. A report of these activities as they have been completed have been furnished for orientational purposes to all groups participating in our planning project.

Subcontracts

Since it was felt important to determine the numbers of people within the state who need vocational rehabilitation services, it was felt that a population survey should be made. Since such an undertaking is extremely technical and involves the use of more paid manpower than was available to the study staff, a subcontract was let with the Department of Sociology and Anthropology, North Carolina State University, to study the population. A detailed description of the study will appear in Chapter IV of this text along with charts, interpretations, etc. It is of interest at this point, however, to mention there has been concern about the results of the population survey since the prevalence of disabling conditions reported were far greater than national estimates and reports seen from other states whose planning projects have been completed. However, a comparison of the North Carolina material with other studies done in this state and with the Social Security Survey of the Disabled—1966, has given us confidence that the conclusions reached in this project have validity.

Another area of the study which has been subcontracted and which will be reported in a separate volume is a study of the administrative and organizational structure of the Rehabilitation Agency in North Carolina. This subcontract was let because none of the committees of the study nor any of the staff had enough expertise in administration and organization of rehabilitation programs on a state-wide basis to legitimately undertake such a project. Other reasons for subcontracting this part of the study was the felt need for having an out-of-state group look at the North Carolina rehabilitation picture and report its findings with the highest degree of objectivity possible. This was mandatory since there is sentiment in the state to maintain status quo and other sentiment that favors substantial administrative and organizational changes. It was hoped that with the report of this experienced research and consultant firm, there could be a “meeting of the minds” regarding the administrative and organizational structure most desirable.

Conclusions Regarding Organization and Procedure

At this point, the conclusion is that attempts to secure community and citizen involvement have been largely successful. Success can be noted in the depth of studies completed in certain areas. Success is also indicated in that the North Carolina Study has been able to clearly define some of the problems with which the state will have to cope in order to develop a program of the magnitude and scope needed to successfully provide services to its citizens who need rehabilitative services.

There have been failures which have been alluded to earlier in this chapter. Logistics have created what seems to be insurmountable problems for a centrally located, small staff of people to effectively work with all of those in the state who have shown concern and interest in contributing to finding solutions to the problems of the disabled. There have been areas where a lack of internal organization and an inability to provide external leadership for organization has caused gaps in the comprehensive planning effort. It is felt that if the staff had more clearly defined for itself some of the rehabilitation problems to be investigated before the initiation of a statewide organization, the organization could have been more effective.

It is felt, however, that the basic structure of the study and planning effort for vocational rehabilitation was basically sound and that continued efforts with a very similar community organizational structure (state as community) should be carried out. If the efforts of the study are to be of intrinsic value to the state, a formal organization must be maintained so that the citizens who have been involved in the study can interpret to the state legislature and the Vocational Rehabilitation Agency rehabilitation needs and the responsibility of both for meeting these needs.

CHAPTER IV
FINDINGS AND RECOMMENDATIONS

**A SYNTHESIS
OF A SURVEY IN DURHAM, PITT AND TRANSYLVANIA COUNTIES
CONCERNING DISABILITIES**

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SYNTHESIS OF THE SURVEY REPORT IN DURHAM, PITT, AND TRANSYLVANIA COUNTIES CONCERNING THE INCIDENCE, PREVALENCE, AND ATTITUDES CAUSED BY DISABILITY

As part of the attempt to determine the amount of vocational handicaps, and the basic characteristics of the handicapped, the North Carolina Study in Vocational Rehabilitation subcontracted with the Department of Sociology and Anthropology of North Carolina State University to conduct an intensive survey in three North Carolina counties. This report represents a synthesis of the findings of the research carried out in the summer of 1967. A more detailed analysis can be found in Volume I of the research publication.

A study of the State as a whole was made prohibitive by the costs involved. As an alternative, three counties, representing the three geographic regions within North Carolina were selected. Each of the counties is supported by a different type of economic base. Durham County has an industrial economy, Pitt County an agricultural economy, and Transylvania County's economy is primarily a mixed economy with a high rate of part-time farming. Care was taken to select a county with a large nonwhite population, a second with a ratio equivalent to that of the State as a whole, and a third county with a low nonwhite population. Within each county a random sample was selected using 1960 census data. The sample areas were selected in clusters so that approximately 15 households within each area were to be interviewed. The designated areas were marked on large maps and the actual data were gathered by a team of interviewers, each armed with a lengthy questionnaire. The sample cannot be said to be completely random inasmuch as the enumerators were instructed to interview a physically handicapped adult whenever such a person appeared in the household.

The two most salient sources of vocational disabilities gleaned from the data were educational and physical handicaps. It is these two spheres which serve as the basis of orientation of this report.

Educationally Handicapped

In the course of the interview the respondent was presented a paired list of factors which most often contribute to vocational handicaps. The list included physical handicaps, educational deficiencies, racial discrimination, and various emotional problems. The completed list set each of these problems against the other in a series of pairs so that each problem could be seen in relation to every other problem. The respondent actually had three choices in each listing which asked him to select whichever of the two problems had impaired his own vocational efforts or to indicate "neither." Thus the question was stated, which of the following has acted as a vocational handicap in our life: Lack of Education—Physical Handicap—Neither. The next question would then juxtapose Lack of Education—Race—Neither. This was continued until every major source of handicap could be viewed in comparison with each of the other sources of vocational handicap. Persons who consistently cited a particular problem every time that it appeared in the questioning or at least on three out of the four occasions where it appeared were defined as being handicapped by that problem. In the case of the educationally handicapped the division in this analysis compares those who consistently reported an educational deficiency with those respondents who did not report any evidence of educational shortages.

In Durham and Transylvania Counties one-third of the persons interviewed consistently cited the lack of education as a vocational handicap. In Pitt County almost half or 46 percent of the persons interviewed indicated consistently that the lack of education had been a vocational handicap. While most of the people in any given population might be able to cite instances in which more or better education would have been beneficial in their vocational opportunities, they are unlikely to seriously

suggest that lack of education has been a vocational handicap. For that reason over half of the respondents in Durham and Transylvania Counties did not cite the lack of education as a vocational handicap during the course of the interview. In Pitt County however, a majority of the respondents did indicate during the course of the interview that lack of education had served as a vocational handicap.

Of those persons consistently indicating a lack of education, two-thirds had not finished high school in Durham and Transylvania Counties and 88 percent had not finished high school in Pitt County. By way of contrast, over two-thirds of the persons who did not indicate education as a vocational impairment had completed at least their high school training.

The problem of low education, as is the case with other vocational handicaps, tends to be compounded by other inhibiting factors. Consequently while lack of education seems to be at the core of the problem for many of these respondents, it is not acting singularly in producing the undesirable situation. Thus Negroes often expressed the thought that being a Negro meant that they came out of circumstances which lessened the chance of acquiring an adequate education. There is no doubt that Negroes appear far out of proportion among the educationally handicapped. In Durham County 65 percent of the Negroes stated that lack of education had been the major vocational encumbrance. Seventy-two percent of the Negroes in Pitt County responded similarly, and 82 percent of Negroes interviewed in Transylvania County reported the lack of education as a problem in gaining adequate employment.

The lack of education is consistently correlated with low income. The findings in this survey offered no variance in this respect. Twenty percent of the educationally handicapped respondents in Transylvania County reported an annual family earning of less than \$2,000. Six percent of the persons in the same county who indicated no education handicaps were in this low income bracket. An even higher percentage of educationally handicapped in Durham and Pitt Counties earned less than \$2,000. Twenty-three percent of the respondents reporting an educational deficiency in Durham and 46 percent of the educationally handicapped in Pitt County were in such a low economic category.

Not only was the income low, but these same handicapped respondents saw little hope for any substantial increase in the future. Hopes of moving to a new area in which other opportunities might be sought were only rarely expressed. Mobility aspirations of this type seemed in themselves unrealistic. Even though the educationally handicapped stated that they thought that job opportunities for people like themselves were poor in the present area, a majority of these same respondents said that they could not afford to move as far as 50 miles away, even if they knew of a job.

The clustering of these vocational problems manifests itself not only in terms of their cumulative effect upon the particular respondent, but also its impact on whole families. The educationally handicapped were found to be much more likely to have brothers and sisters who had dropped out of school. Such a situation helps to establish failure as part of the normalcy which he has come to expect. The whole history of economic impoverishment extends horizontally in terms of the respondent's brothers and sisters and vertically with his parents and children. The contemporary literature in the field is replete with this type of problem families. In the light of such circumstances it is not surprising that the educationally handicapped scored so high on the anomie scale.

Anomie is a French term which literally translated means "normlessness." The term was applied to the study of society by Emile Durkheim in the late nineteenth century. Durkheim found that persons who held goals and aspirations which were far beyond their means of achievement, or for whom there were rigid barriers between their present position and their goals, would suffer a sense of frustration or anomie. The term has come to be associated with acute frustration and pessimism and Durkheim himself found this factor to be a major contributor to suicide. Anomie is of concern in this paper because of the mental problems which this situation creates in terms of rehabilitative processes as well as the restraints which it imposes on any self-help possibilities. The questionnaire made use of Srole's Anomia Scale which is designed to measure the degree of alienation and pessimism which the respondent feels.

The percentage of persons scoring high on the anomie scale was four times as great among the educationally handicapped in Durham and Pitt County when compared to the population reporting

no educational handicap. Scores for the educationally handicapped were higher than those made by the nonhandicapped group in Transylvania County, though not as dramatic. The sense of negativism implied by this measurement is appalling and reflects very deep attitudinal problems which would multiply the difficulty of effective rehabilitation.

The educationally handicapped, unlike many of the physically handicapped discovered in the course of the survey, are in the age category in which there are many children still in the home. The pattern of large numbers of children beginning work at an early age in a home under severe economic strains anticipates the circular model of poverty discussed so frequently in the contemporary literature. In spite of an otherwise morbid picture, approximately three-fourths of the educationally handicapped held out the hope that their children would receive more education than they had received. More education for the children was the premier hope of almost every educationally handicapped person encountered.

Physically Handicapped

The very nature of the type of the research conducted necessitated that the interviewer rely upon the statement of the respondent to determine whether or not he was physically disabled. In addition to the paired statements cited earlier one major section of the questionnaire concentrated exclusively on physical, mental, and emotional handicaps. Those persons who consistently reported physical handicaps when responding to the paired questions also indicated on subsequent questions the degree and nature of their handicap. The division used in the analysis for this report divided the respondents into the categories of non-handicapped, partially handicapped, and totally handicapped on the basis of the respondent's judgment and the amount of work he was able to perform during the previous year.

The data reveal a higher percentage of physical handicaps in the three counties than had been anticipated. Sixteen percent of the respondents in Durham County reported being partially disabled, and 5.9 percent said that they were totally disabled. The consistency of these figures is evidenced by the fact that 18 percent of the respondents in Pitt County indicated that they were partially disabled and 6.6 percent stated that they were totally disabled. Eighteen percent of the Transylvania County respondents related that they had a partial disability and 3.3 percent indicated a total disability.

The single most important factor in explaining such a high rate of physical disability is found in the age factor. Approximately 60 percent of those persons reporting a partial disability in each of the counties is fifty years of age or older. In Durham and Pitt Counties an even larger percentage of those reporting total disabilities are over fifty years of age. Approximately two-thirds of the totally disabled in Durham are in this age category and 90 percent of the totally disabled in Pitt County are over fifty years of age. Forty-four percent of the totally disabled in Transylvania County are over the age of fifty. Among the adult population as a whole, approximately one third are over fifty. By following the practice of deliberately seeking out the physically handicapped within a family as the respondent, there arose the corollary situation of biasing the sample in favor of the older group since they will necessarily have greater impairments on their physical activities.

Table 1
Age and Disability

Age Groups	18-34		35-49		50 +	
	partial disability	total disability	partial disability	total disability	partial disability	total disability
Durham	5.9	1.0	14.0	4.9	23.7	9.9
Pitt	7.1	0.8	13.5	1.4	28.9	14.4
Transylvania	6.2	0.0	18.2	6.5	28.7	3.9

Table 1 reveals that even when the age factor is taken into account a rather high percentage of physical disabilities persists in each of the age groupings.

The younger age groups contained relatively few totally disabled persons. Nevertheless approximately six percent of even the youngest age group reported a partial disability. The problem of chronicity was unlikely to be a factor at this stage in their lives, but on the nonphysical side there was evidence of low educational attainment which will tend to aggravate the physical problems. The accumulation of physical impairments which are a part of the maturation process plus the probability that the longer one does physical labor the more likely he is to suffer from a physical impairment is readily seen in Table 1. Approximately one-third of the respondents over fifty years of age reported a physical disability.

The findings of the research was consistent with other studies in the high incidence of physical handicaps among nonwhites. In both Durham and Pitt Counties 22 percent of the Negro respondents reported a partial disability. Eight percent of the nonwhites in Durham and 9 percent in Pitt reported total disabilities. By contrast 11 percent of the whites in both Durham and Pitt Counties stated that they were partially disabled and approximately 5 percent said they were totally disabled. Thus the reported physical disabilities among nonwhites was almost double that found among the white respondents. The small Negro population in Transylvania County does not permit entirely meaningful statistics in this regard. Nevertheless it is interesting to note that 25 percent of the nonwhites and 13 percent of the whites reported partial disabilities, or again a rate of approximately two to one.

While an earlier citing noted the disparity between the income of the educationally handicapped as contrasted with those reporting no similar handicap, such contrasts are not as dramatic as those figures depicting the income of the physically handicapped and the nonhandicapped. The totally handicapped in Durham and Transylvania Counties were almost identical in the percentage of family earnings of less than \$2,000. In both counties approximately 57 percent of the totally handicapped were members of a family which earned less than \$2,000. Eighty-one percent of the totally handicapped in Pitt County indicated an annual family income of less than \$2,000. These figures represent a ratio of persons in the lowest income figures which is from four to seven times as great as the percentage of nonhandicapped in the same counties who were in this low income category. A further means of contrast is to note that 9.7 percent of the whites in the United States and 30.8 percent of the nonwhites earned less than \$2,000.

At the very roots of the problems of the physically handicapped encountered in this survey is the paucity of education which they have obtained. Only in a small number of cases did the physical handicap itself prevent a complete educational background. Rather the most common problem was the familiar story of economic pressure on the family which forced the children into the job market at an early age. Having failed in the acquisition of an adequate education the individual sought to perform manual work, requiring in a large percentage of cases a high degree of physical expenditure. Such work in itself carries a greater probability of physical injury. Moreover when injury does occur it leaves the victim with little or no recourse in job opportunities.

Table 2 illustrates the extent of the educational deficiency. Seventy percent of the totally disabled respondents in Durham received less than nine years of schooling, or in other words did not spend even a single day in high school. In Pitt County an even more ominous figure of 83 percent of the totally handicapped were found to have less than nine years of schooling. Only three out of 184 partially disabled respondents in the three counties had finished college, and not a single respondent who reported that he was totally disabled had a college degree. Only three totally disabled respondents out of a total of 161 had even attended college. The lack of education among the totally disabled can perhaps best be dramatized by indicating the high rate of illiteracy. The illiteracy rate among the totally disabled is 18 percent, 33 percent, and 22 percent in Durham, Pitt and Transylvania respectively.

Figure 1 is designed to demonstrate the disparity in the educational levels of the totally handicapped when contrasted with the non-physically handicapped.

In each county the percentage of high school graduates among the nonhandicapped more than doubles the percentage among the totally handicapped. The percentage of high school graduates among the nonhandicapped in Pitt County exceeded the percentage of totally handicapped with a high school diploma by seven fold.

Figure 1

Percentage of High School Graduates Among Totally Disabled and Non-disabled Respondents

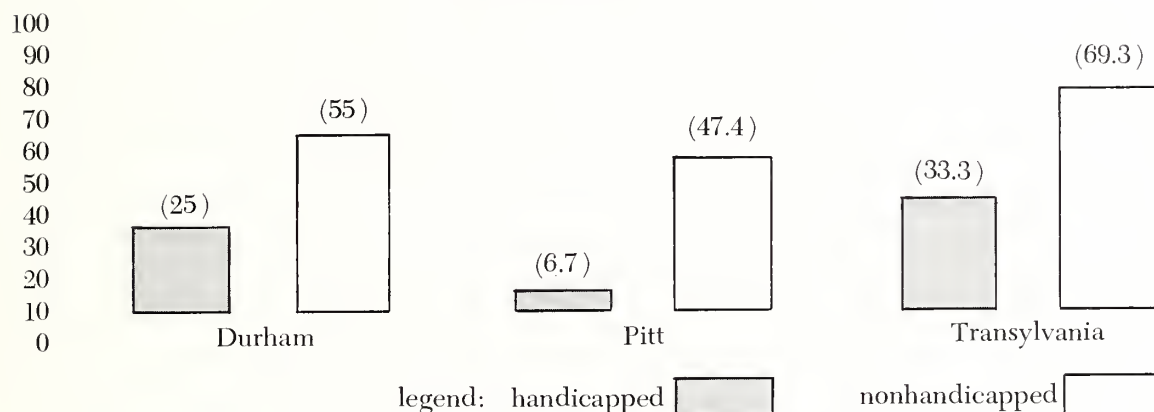


Table 2

Educational Attainment of the Physically Handicapped

	No Education	1-4 yrs.	5-8 yrs.	9-11 yrs.	Finished High School	Some College	Finished College
<u>Durham</u>							
Partially Disabled	6.9	12.1	36.2	15.5	17.2	10.3	1.7
Totally Disabled	1.0	30.0	30.0	5.0	20.0	5.0	0
<u>Pitt</u>							
Partially Disabled	8.9	19.0	29.1	16.5	11.4	10.0	5.1
Totally Disabled	3.3	43.3	36.7	10.0	6.7	0	0
<u>Transylvania</u>							
Partially Disabled	8.2	20.4	28.6	8.2	20.4	12.2	0
Totally Disabled	0	44.4	0	22.2	11.1	22.2	0

The significance of the physical handicap, compounded by low education, cannot be explored in its entirety. Nevertheless certain salient consequences should be noted. The author of this report agrees with the countless observations that education is indeed the principle avenue for upward mobility in the United States. The early curtailment of education which leaves many young men with economic aspirations, but without the vehicle of formal training is a primary contribution to juvenile delinquency and crime among the younger age groups. An alternative to criminal behavior is a withdrawal from the broader society and an increased sense of alienation. Lacking not only the skills which are often a

direct result of the education, but the sense of discipline and values which are an integral part of the educational process itself, these educationally and physically handicapped displayed an inability to seek a realistic solution to their problems. The prolonged consequences cited herein have already made themselves felt in the major metropolitan areas of the United States. North Carolina faces this morbid prospect as urbanization increases. Such respondents did however perceive that more education for their children was the best measure of assuring the next generation a better life. Consistently these persons reported the desire for their children to be able to gain a full education. In the course of expressing such hopes the respondent often indicated that with additional education the physical limitations imposed on him would have been minimized. It seems reasonable to assert that the full impact of the physical disabilities would have been markedly reduced and in some cases negligible if the educational level had been more in line with the national average.

The physically handicapped agreed that there would be little or no advantage in seeking employment in a different area. Moreover, two-thirds of the totally disabled respondents in Durham and Transylvania Counties indicated that they were financially unable to move as far as fifty miles away. Over 90 percent of the totally disabled in Pitt County said that they did not have the money to make such a move.

In the face of these disadvantages it is not surprising that the physically handicapped exhibited the highest degree of anomie. The percentage of persons scoring in the highest category on the anomie scale was two to three times as great among the handicapped when compared to the nonhandicapped. This sense of despair and alienation manifested itself not only on the anomie scale but in the verbalization of other attitudes and in the general conversation between the interviewer and respondent.

SUMMARY AND CONCLUSION

The number of persons who view themselves as having highly restrictive vocational handicaps in the three North Carolina Counties surveyed is appallingly high and includes over one-third of the respondents interviewed. Two of the most frequent sources of these vocational handicaps were the lack of education and physical handicaps, often with the two factors occurring in conjunction. Whether the respondent designated education or a physical disorder as the genesis of his problem, there is the unmistakable evidence that no single factor accounted for the resulting vocational handicap. The problem was invariably multi-faceted. The handicapped respondents were often of a minority race and quite often came from families which had exhibited similar vocational problems in the previous generation. Because of present economic pressures in the family, the prognosis is that this pattern will spill over into the next generation as well. In the case of the physically handicapped their problems are augmented not only by the factors cited above, but also by age and a lack of education. The sense of despair and alienation among the handicapped has reached an alarming degree and shows little indication of waning.

**IMPLICATIONS OF THE POPULATION SURVEY AND
DISCUSSION OF SOCIO-CULTURAL DEPRIVATION AS A HANDICAPPING CONDITION**

Implications of the Population Survey

On the preceding pages is a synthesis of survey findings in Durham, Pitt, and Transylvania counties concerning the incidence, prevalence, and attitudes caused by disability. An in-depth study was completed under subcontract with the North Carolina Study, during the summer of 1967 by the Department of Sociology and Anthropology, North Carolina State University, under the direction of Vaughn L. Grisham.¹

The estimates of disability reported by the above study² are somewhat higher than expected, but are comparable to figures reported in other studies done in North Carolina³ and to those published by the Social Security Administration.⁴ The chart in Chapter V, page 289, indicated the 1975 projected need and cost of needed services, based on the estimates provided by the North Carolina population survey. The footnotes at the end of the chart point out some inadequacies in the data reporting system of the North Carolina Division of Vocational Rehabilitation which prevented the computation of a "true" acceptance rate by disability. Since a large number of rejected referrals were not identified by disability, the acceptance rates for each disability category may have been lower than the figures used.

Because of these inadequacies, the North Carolina Study *IS RECOMMENDING THAT CHANGES BE MADE TO CORRECT SUCH DEFICIENCIES IN REPORTING. ONE MAJOR CHANGE NEEDED IS AN INCREASE IN THE AMOUNT AND KINDS OF INFORMATION OBTAINED ON EACH "08" CLOSURE. RACE, DISABILITY CATEGORY AND SPECIFIC REASON FOR REJECTION ARE ITEMS WHICH SHOULD BE REPORTED, AS WELL AS WHETHER OR NOT THE PERSON IS REFERRED TO ANOTHER AGENCY FOR SERVICES.*⁵ Such information is essential to ongoing planning for better and increased rehabilitation services. *IT IS ALSO RECOMMENDED THAT A STUDY BE MADE BY THE AGENCY OF THE CASES CLOSED FROM REFERRAL TO DETERMINE WHY SO LARGE A NUMBER OF APPLICANTS ARE NOT ACCEPTED FOR SERVICES.* Such a study would include personal interviews with rejected referrals as well as interviews with the counselors involved. It is estimated that approximately \$5,000 would be needed to complete a study of this nature. At least four interviewers would be recruited to interview a sample of "08" closures in representative areas of the state.

A major goal of the above-mentioned population survey of North Carolina was to uncover the sociocultural barriers that accompany vocational handicaps and often are primary factors in preventing or delaying remedial progress. The use of an anomie scale⁶ was one attempt to achieve this goal. The fact that those persons reporting some degree of disability, either physical or sociocultural, exhibited a higher degree of anomie (normlessness) than did those reporting no disability is an indication that the Vocational Rehabilitation agency needs to upgrade its counseling and guidance function. This need has also been expressed over and over in testimonies given at public hearings⁷ held throughout the state and by agency personnel who participated in the Sixteen-County Interagency Survey⁸ sponsored by the North Carolina Study.

¹For the complete report, see Vaughn L. Grisham, *A Report of a Survey in Durham, Pitt and Transylvania Counties Concerning Disabilities*, N. C. Study in Vocational Rehabilitation, Volume I.

²See pages 53-55 for tables giving these estimates.

³William P. Richardson and A. C. Higgins. *The Handicapped Children of Alamance County North Carolina*. Nemours Foundation, Wilmington, Delaware, c. 1965.

⁴*The Social Security Survey of the Disabled: 1966*. U. S. Dept. of Health, Education, and Welfare, Social Security Administration.

⁵See Martin Dishart, *Vital Issues and Recommendations from the 1965 National Institutes for Rehabilitation Research*, National Rehabilitation Association, Washington, D. C., 1965, pp. 8-13, for additional discussion of this recommendation.

⁶See page 42.

⁷See page 129 for a report of these hearings.

⁸See page 181 for a report of this survey.

Another aspect of the North Carolina population survey involved the respondents' knowledge and use of public agencies, including Vocational Rehabilitation. The following tables (3 thru 7) extracted from the full survey report, indicate a general lack of knowledge of local service agencies. This lack of knowledge has also be expressed by numerous agency personnel who answered the questionnaire for the previously mentioned Interagency Relationships Study. It is interesting to note in Table 7 that few of those indicating a knowledge of Vocational Rehabilitation's existence could name any specific service provided by the agency.

It is also significant that Vocational Rehabilitation was not listed by respondents as an agency in the item represented in Table 4. The very first problem recognized and discussed by the Governor's Study Committee on Vocational Rehabilitation was the lack of public visibility of the Vocational Rehabilitation Agency. One point of discussion in several public hearings was that Vocational Rehabilitation does not have a clear community identity.¹ This lack of public identity is a problem which must be solved if the state is to ever recognize the full potential of its Vocational Rehabilitation program. Specific recommendations and plans that may ameliorate this problem are presented in Chapter VI, page 301.

Table 3. Lack of Knowledge of Local Agencies²

Categories	DURHAM CO.		PITT CO.		TRANSYLVANIA CO.	
	Number	Percent	Number	Percent	Number	Percent
Could not name one	129	34.2	166	36.6	85	31.0
Could not name two	233	61.8	289	63.8	150	54.7
Could not name three	305	80.9	377	83.2	255	82.1
Could not name four	341	90.7	428	94.6	258	94.2

Table 4. Respondent's Knowledge of Local Agencies³

Name of Agency	DURHAM		PITT		TRANSYLVANIA	
	Number	Percent	Number	Percent	Number	Percent
Public Health	157	44.6	199	43.7	154	56.2
Public Welfare	117	31.0	149	32.7	102	37.2
Employment Security	82	21.8	115	25.3	55	20.1
OEO	23	6.1	4	0.8	6	2.2
Social Security	14	3.7	3	0.7	5	1.8
Agricultural Ext.	4	6.0	29	6.3	1	0.4
Other public agencies	74	19.6	35	7.6	23	8.4
Mistook private for public agency	28	7.4	18	3.9	21	7.7

Table 5. Ever Made Use of a Public Agency

Responses	DURHAM		PITT		TRANSYLVANIA	
	Number	Percent	Number	Percent	Number	Percent
Yes	210	55.7	216	47.7	134	48.9
No	166	44.0	237	52.3	140	51.1
Unknown	1	.3	0	.0	0	.0
Totals	377	100.0	453	100.0	274	100.0

¹See summary of Salisbury and Cullowhee Public Hearings, pages 140, 142.

²Each respondent was asked to list at least 4 local public agencies.

³Since one person might have named more than one agency, the percentages indicate the percent of the total sample who named a particular agency.

Table 6. Heard of Vocational Rehabilitation

Responses	DURHAM		PITT		TRANSYLVANIA	
	Number	Percent	Number	Percent	Number	Percent
Yes	248	65.8	256	56.5	146	53.3
No	128	33.9	197	43.5	127	46.3
Don't Know	1	.3	0	.0	1	.4
Totals	377	100.0	453	100.0	274	100.0

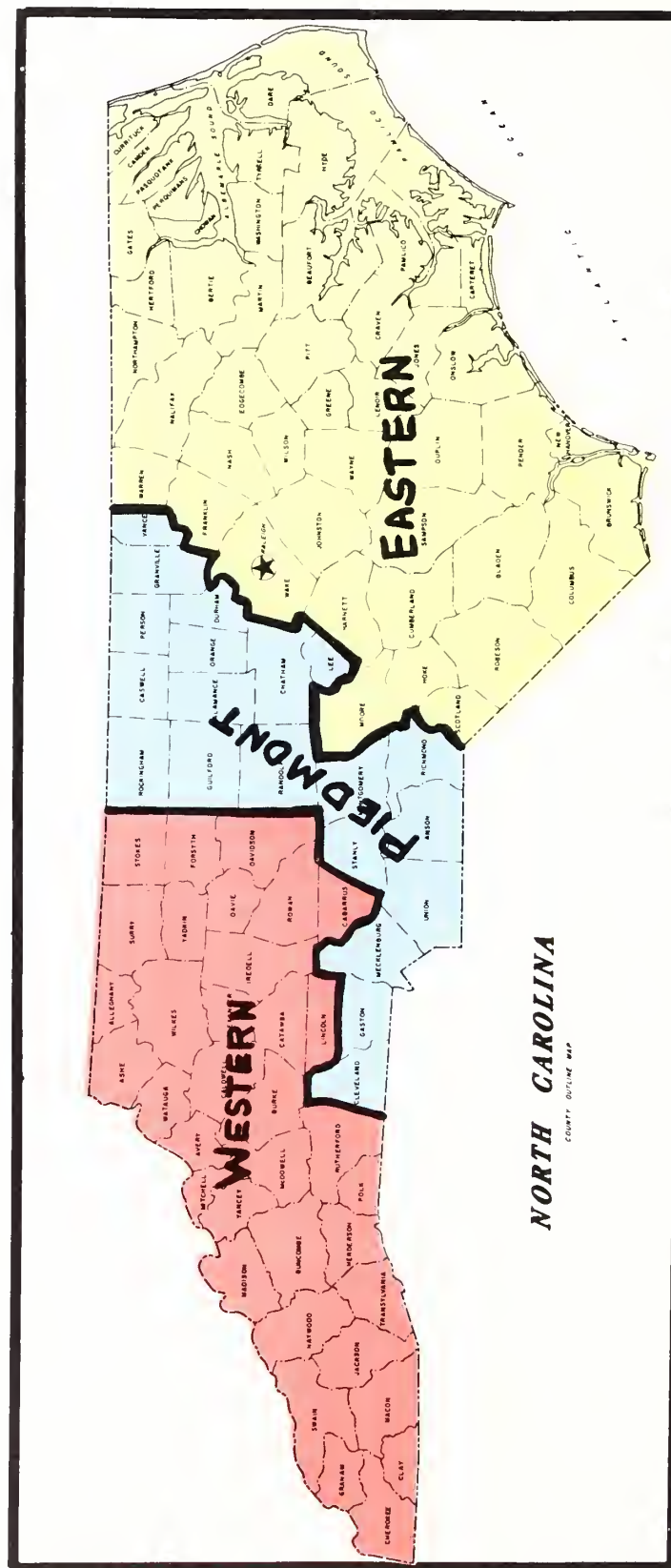
Table 7. Respondent's Knowledge of Services Provided by Vocational Rehabilitation¹

Services ²	DURHAM		PITT		TRANSYLVANIA	
	Number N = 248	Percent	Number N = 256	Percent	Number N = 146	Percent
Job training	98	25.9	82	18.0	53	19.3
Job placement	31	8.2	23	5.0	9	3.3
Counseling	6	1.6	2	0.4	1	0.4
Providing equipment	9	2.3	8	1.7	3	1.0
Opportunity to gain additional education	31	8.2	23	5.0	15	5.4
Psychiatric treatment	2	0.5	1	0.2	2	0.7
Payment of hospital bills	17	4.5	21	4.6	12	4.4

¹ These figures are applicable only to those persons who indicated that they had heard of Vocational Rehabilitation.

² Respondents were asked if they could name at least three services provided by the Vocational Rehabilitation Agency. The percentages indicate the percent of respondents who named a particular service.

Figure 2



On the following pages are tables showing the estimates of disability projected for North Carolina. The map above indicates the three geographical divisions used in making these estimates for the state as a whole.

Table 8
ESTIMATED PREVALENCE OF DISABILITY IN NORTH CAROLINA
1967

Categories	REGIONS			
	WESTERN	PIEDMONT	EASTERN	TOTAL
Visual impairments	20,234	19,740	45,889	85,863
Hearing impairments	6,745	13,136	16,405	36,286
Orthopedic deformity or impairment	97,827	134,787	193,445	426,059
Absence or amputation of Limbs	23,607	13,136	9,843	46,586
Mental, Psychoneurotic & Personality Disorders ¹	16,862	39,444	32,765	89,071
Leukemia & other conditions resulting from neoplasms	3,372		13,124	16,496
Allergic endocrine system, metabolic & nutritional diseases	16,862	19,740	13,124	49,726
Diseases of the Blood	3,372	3,284		6,656
Disorders of Nervous System			3,281	3,281
Cardiac & Circulatory Conditions	50,614	49,295	75,419	175,328
Respiratory Diseases	13,489	16,420		29,909
Disorders of the Digestive System	6,745	13,136	9,843	29,724
Conditions of Genito- Urinary System	6,745	9,852	3,281	19,878
Other Cultural & Social deprivation ^o	16,862	32,839	39,327	89,028
TOTALS	283,336	364,809	455,746	1,103,891

* See maps and comments on following pages.

¹ This is one category in which we feel our projections are far too conservative. The Mental Retardation Planning Program (Mandate for Tomorrow: Comprehensive Planning in Mental Retardation in North Carolina, North Carolina Council on Mental Retardation, December 31, 1965) estimated slightly less than 4% mentally retarded, which equals about 200,000 people. This includes those persons with a measured I.Q. of less than 75. The Vocational Rehabilitation Agency now serves people on the basis of mental retardation with an I.Q. up to 85. According to the standard normal curve this includes 17.5% of the population.

Table 9
ESTIMATED PREVALENCE OF DISABILITY IN NORTH CAROLINA
1970

Categories	REGIONS			
	WESTERN	PIEDMONT	EASTERN	TOTAL
Visual impairments	20,679	20,562	46,638	87,879
Hearing impairments	6,893	13,683	16,673	37,249
Orthopedic deformity or impairment	99,976	140,402	196,603	436,981
Absence or amputation of Limbs	24,125	13,683	10,004	47,812
Mental, Psychoneurotic and Personality Disorders ¹	17,232	41,087	33,300	91,619
Leukemia & other conditions resulting from neoplasms	3,446		13,338	16,784
Allergic, endocrine system, metabolic & nutritional diseases	17,232	20,562	13,338	51,132
Diseases of the Blood	3,446	3,421		6,867
Disorders of Nervous System			3,335	3,335
Cardiac & Circulatory Conditions	51,726	51,349	76,650	179,725
Respiratory Diseases	13,786	17,104		30,890
Disorders of the Digestive System	6,893	13,683	10,004	30,580
Conditions of Genito- Urinary System	6,893	10,262	3,335	20,490
Other	17,232	34,207	39,969	91,408
Cultural & Social deprivation*				
TOTALS	289,559	380,005	463,187	1,132,751

* See maps and comments on following pages.

¹ See footnote 1 on preceding page.

Table 10
ESTIMATED PREVALENCE OF DISABILITY IN NORTH CAROLINA
1975

Categories	REGIONS			
	WESTERN	PIEDMONT	EASTERN	TOTAL
Visual impairments	21,576	22,454	48,282	92,312
Hearing impairments	7,192	14,942	17,261	39,395
Orthopedic deformity or impairment	104,316	153,316	203,530	461,162
Absence or amputation of Limbs	25,172	14,942	10,356	50,470
Mental, Psychoneurotic & Personality Disorders ¹	17,980	44,866	34,473	97,319
Leukemia & other conditons resulting from neoplasms	3,596		13,808	17,404
Allergic, endocrine system, metabloic & nutritional diseases	17,980	22,454	13,808	54,242
Diseases of the Blood	3,596	3,735		7,331
Disorders of Nervous System			3,452	3,452
Cardiac & Circulatory Conditions	53,971	56,072	79,350	189,393
Respiratory Diseaes	14,384	18,677		33,061
Disorders of the Digestive System	7,192	14,942	10,356	32,490
Conditions of Genito- Urinary System	7,192	11,206	3,452	21,850
Other Cultural & Social deprivations ^o	17,980	37,354	41,377	96,711
TOTALS	302,127	414,960	479,505	1,196,592

* See maps and comments on following pages.

¹See footnote 1 on page 53.

SOCIAL AND CULTURAL DEPRIVATION

The maps on the succeeding pages present summary indices of deprivation based on the number of persons with low income, insufficient schooling, men not working, and high infant mortality. These maps were copied from maps prepared by the North Carolina Mental Health Planning Staff.¹ From cursory observation it does not appear that these figures are different from those found by Mr. Grisham in the population survey discussed in the preceding section; however, the way Mr. Grisham's data is presented prevented our staff from combining the necessary factors to obtain an accurate deprivation index from the survey findings.

Using the Mental Health figures of a 10% deprivation index for whites and 27% for nonwhites, the estimated number of socially and culturally deprived in North Carolina would be the following:

373,000	white*
<u>343,000</u>	nonwhite*
716,000	Total for state

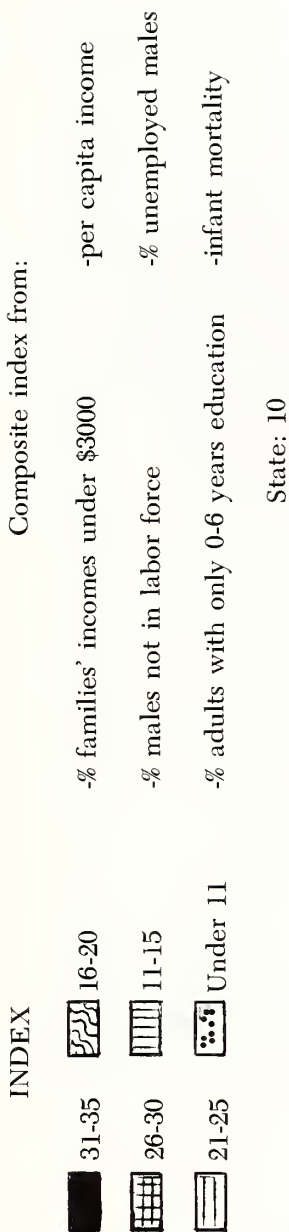
These figures are not intended to suggest this state has 716,000 handicapped persons in addition to those already enumerated on pages 69-71. Physically and mentally disabling conditions overlap with socio-cultural deprivation, so the categories are not independent of one another.² Refer to the survey synthesis at the beginning of this chapter for a discussion of the clustering of vocational problems as found in the population survey. Such overlap prevents the development of a table showing clear-cut categories which are mutually exclusive.

¹Harvey L. Smith, et.al. **Baseline Maps for Mental Health Planning in North Carolina**, North Carolina Mental Health Planning Staff, May, 1965, pp. 34-35.

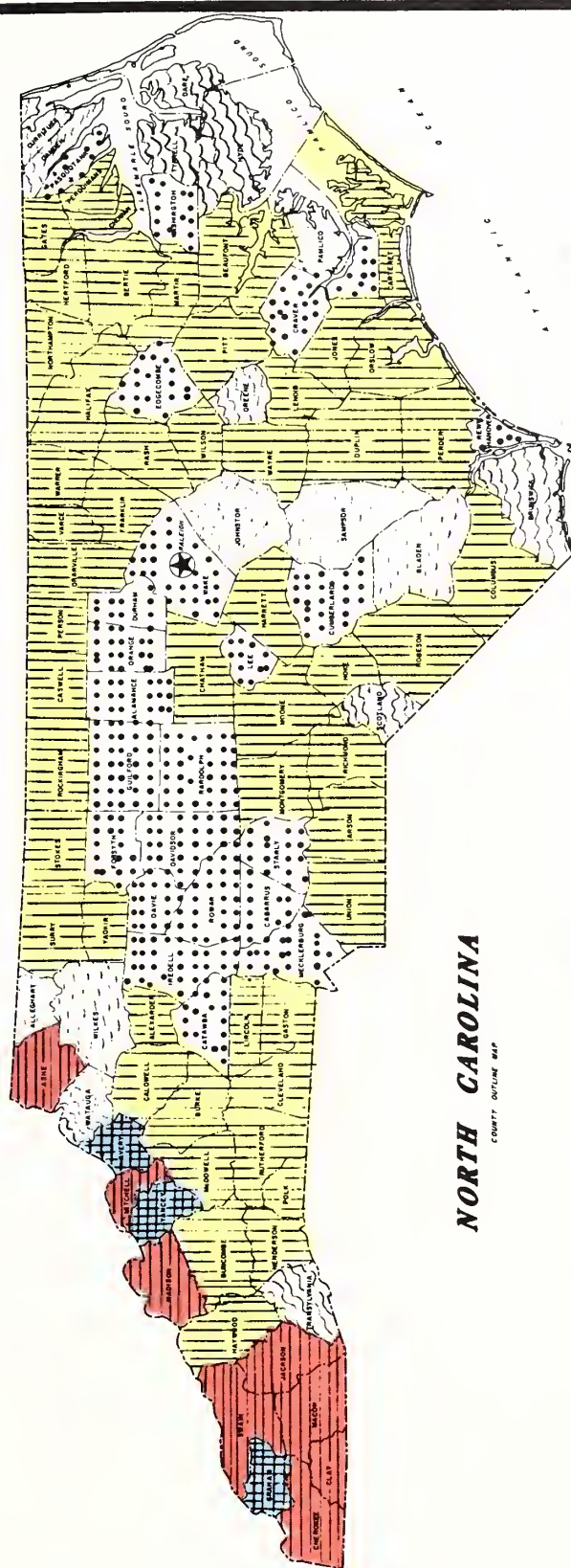
*25.4% of the state's population are nonwhite (1,270,000), 74.6% are white.

²See Vaughn Grisham, **A Report of a Survey in Durham, Pitt and Transylvania Counties Concerning Disabilities**, pp. 130-131, 140-141, 159, and 205-206 for further discussion on this matter.

Figure 3

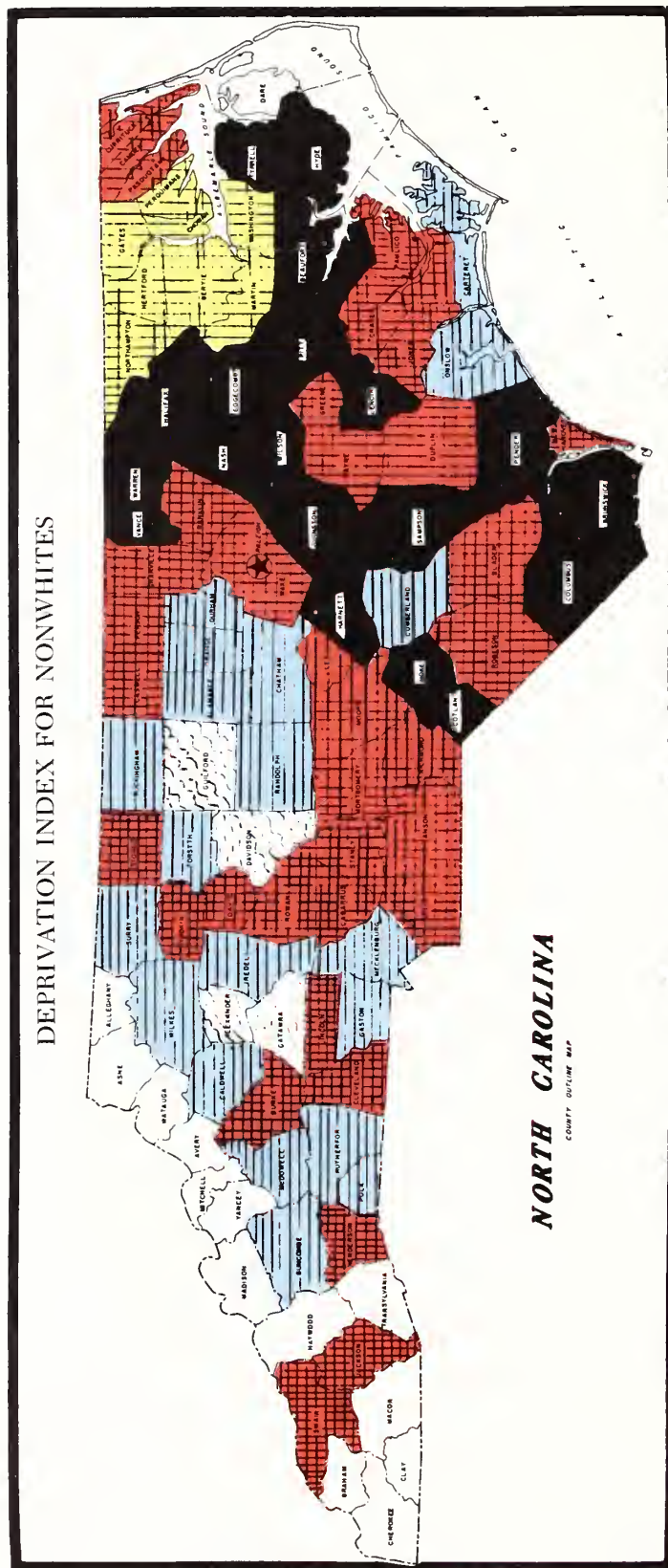
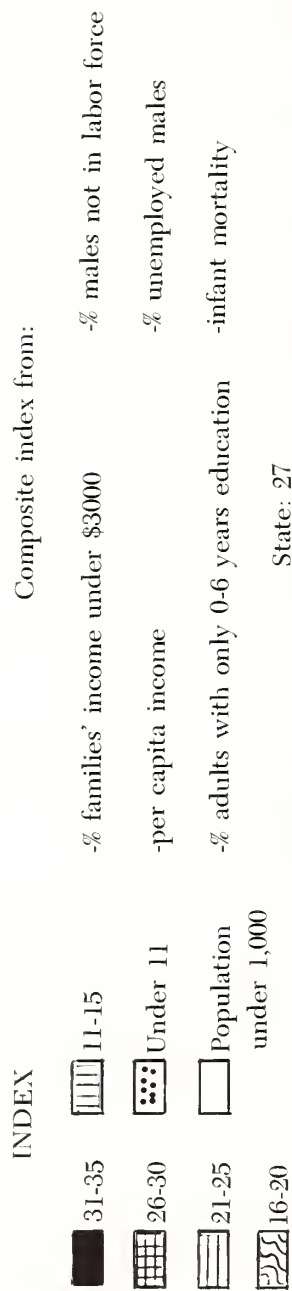


DEPRIVATION INDEX FOR WHITES



The areas on this map which show the highest concentration of deprivation among whites are areas that have few or no rehabilitation resources, such as local offices, workshops, special education units or mental health facilities. As the rehabilitation agency expands its services, expansion should be concentrated in these areas.

Figure 4



This map indicates that the deprivation index for nonwhites is relatively generalized throughout the state. Undoubtedly there are areas without resources where such need to be developed; however, the main implication to be drawn is that there is a need for the Agency to develop a strengthened outreach program directed primarily at deprived nonwhites.

RECOMMENDATION

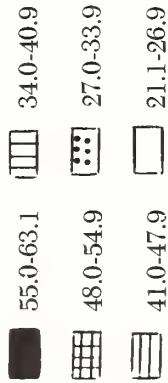
In the immediate expansion of Vocational Rehabilitation Programs the State Agency should concentrate its development in the areas characterized by a concentration of socio-cultural deprivation. It would seem particularly important to develop cooperative school programs in these areas and to give counselors assigned to work in these areas a more concentrated orientation toward the importance of outreach since studies have shown that persons in this population are not apt to seek out nor quickly follow through on programs made available to them. It may be that rehabilitation aides should be initially employed in these areas to perform an intensive outreach function.

Military Rejectees

The following information concerning military rejectees is also taken from the Mental Health Planning Study (see pp. 39-40 of source in footnote 1, page 56 of this chapter). These maps show the percentages of persons who were rejected for military service because they failed to measure up to required standards of education and ability or to standards of physical, mental, or social acceptability. The overall rejection rate for the state for the time period indicated was 53.1%. It should also be noted that the map showing persons rejected for low education and IQ includes those rejected for low education or inaptitude rather than mental retardation per se. It is felt that these figures are indicators of problems with which Vocational Rehabilitation should be concerned.

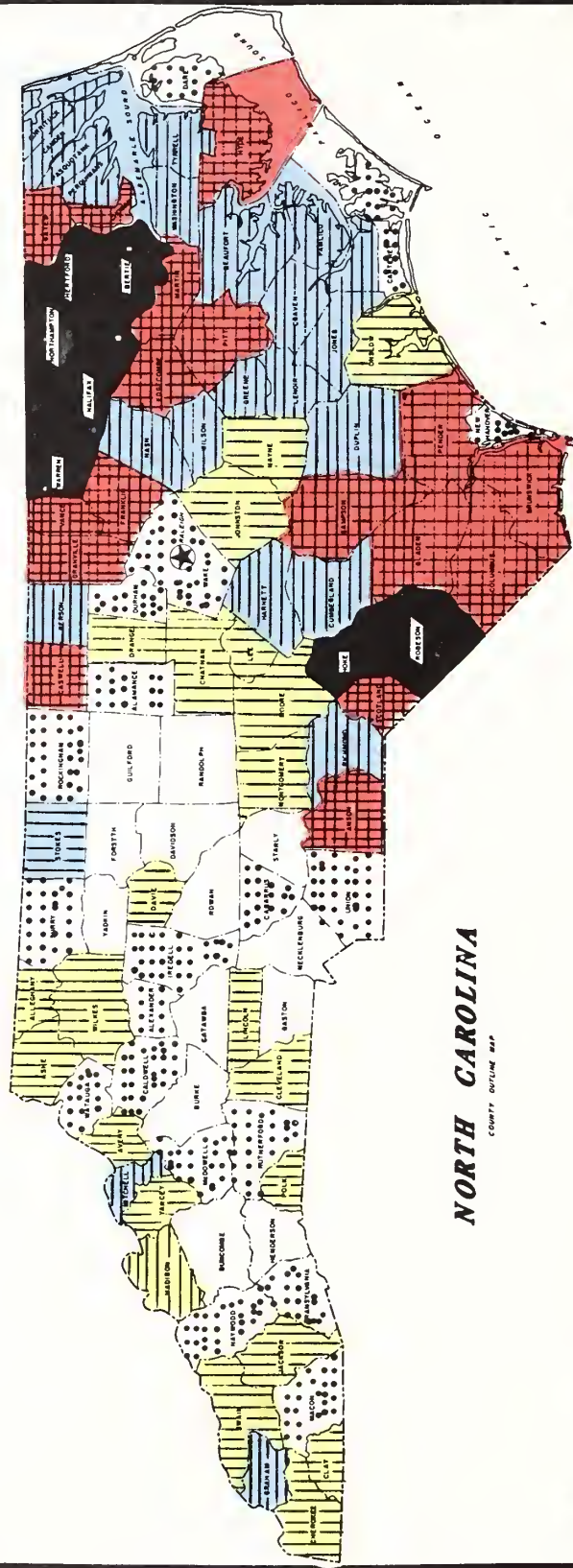
Figure 5

Percent of all persons examined



Highest: Hoke
Lowest: Stanly
State Rate:

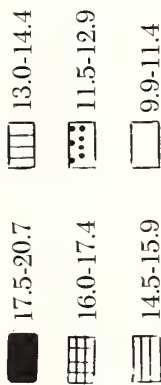
MILITARY REJECTES, 1948-63, FOR MENTAL REASONS-LOW EDUCATION OR IQ



This map illustrates again that the highest concentration of rejectees are from areas with relatively few rehabilitation resources. Such resources should be developed in the areas of highest concentration first and then in the descending categories. Probably the most viable resource needed is the development of cooperative school units and specialized educational approaches.

Figure 6

Percent of all persons examined

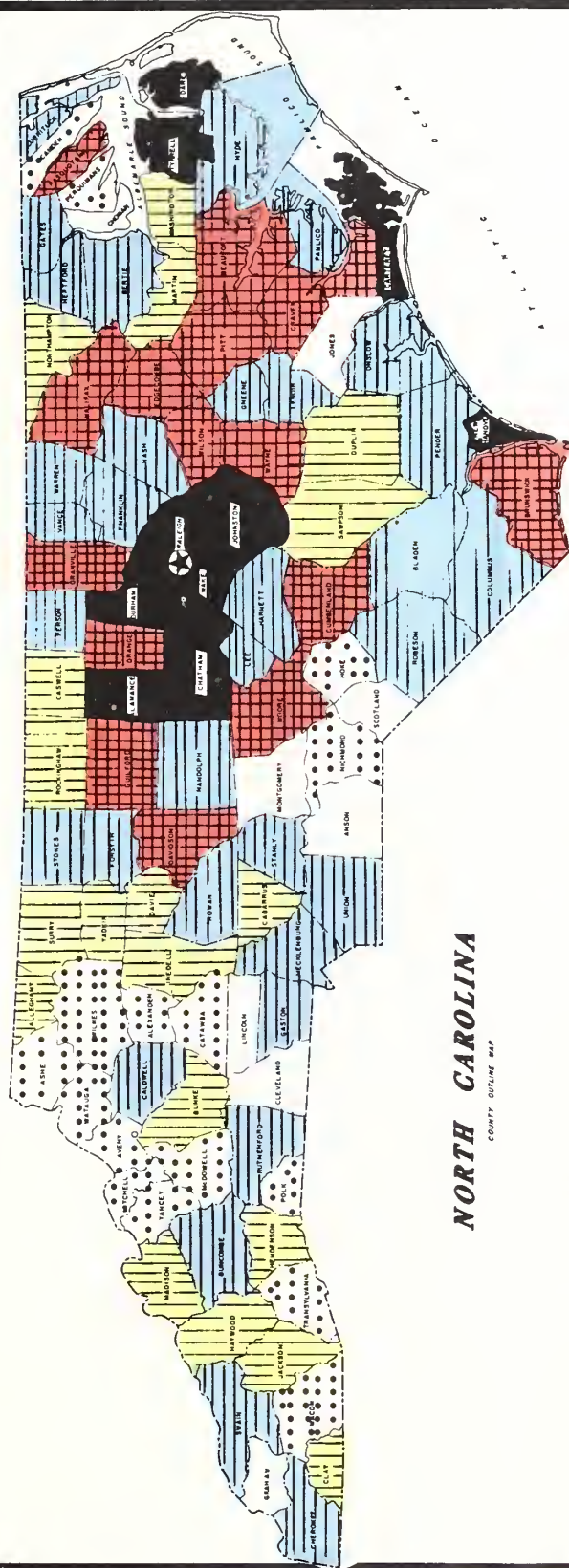


State Rate: 15.1%

Highest: Carteret 20.7%

Lowest: Anson 9.9%

MILITARY REJECTEEES, 1948-63, FOR PHYSICAL REASONS*



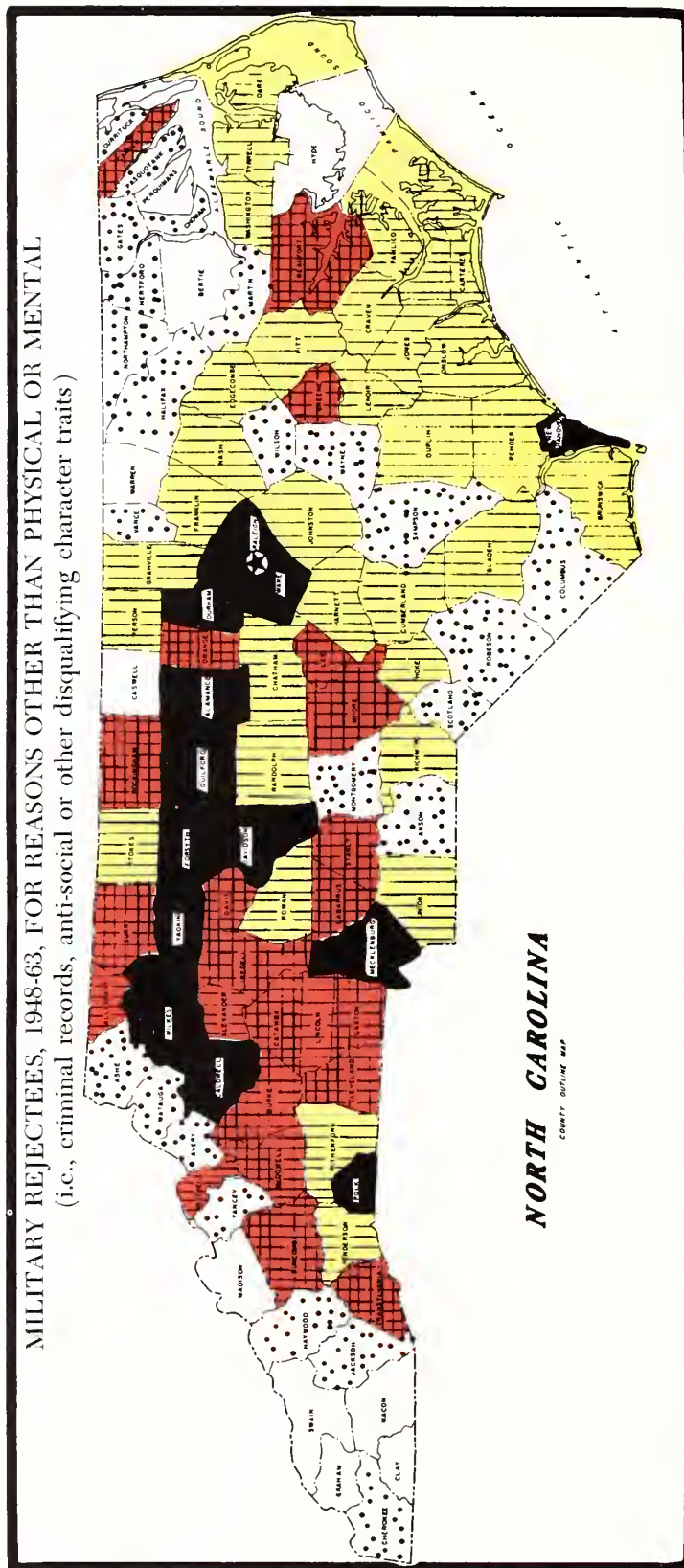
The configuration on this map is very intriguing and any explanation is pure conjecture. Noting that the highest rejection rates are primarily in areas where the best health care should be available, it can be supposed that inductees have a more complete physical history to be considered by military examining physicians. As a result of these histories, conditions are recognized and persons are rejected for service who might not be rejected without a verified history of health problems.

*includes persons rejected for both physical and mental reasons; 'physical' includes psychiatric disqualification; 'mental' refers to mental (IQ) examination.

Figure 7



MILITARY REJECTEEES, 1948-63, FOR REASONS OTHER THAN PHYSICAL OR MENTAL
(i.e., criminal records, anti-social or other disqualifying character traits)



This map graphically depicts that military rejectees for criminal records and anti-social and other disqualifying character traits are concentrated in the areas of highest mobility and the more densely populated sections of the state. The apparent implication for the Vocational Rehabilitation Agency is that as it begins to develop closer, more formalized relationships with juvenile authorities and district courts, the first efforts should be made in the counties where this problem seems most severe.

RECOMMENDATIONS:

- 1. IN AREAS WHERE PERSONS WERE REJECTED BECAUSE OF LACK OF SCHOOLING AND APTITUDE THE CONCENTRATION SHOULD BE ON THE DEVELOPMENT OF COOPERATIVE SCHOOL PROGRAMS.**
- 2. IN AREAS WHERE PERSONS WERE REJECTED FOR PHYSICAL AND MENTAL REASONS, THE VOCATIONAL REHABILITATION AGENCY AND OTHER SOCIAL SERVICE PROGRAMS SHOULD INITIATE PROGRAMS FOR THE EARLY IDENTIFICATION OF PROBLEMS WHICH EVENTUALLY LEAD TO VOCATIONAL HANDICAPS.**
- 3. IN AREAS WHERE PERSONS ARE REJECTED FOR SOCIAL REASONS THE CONCENTRATION SHOULD BE ON BOTH COOPERATIVE SCHOOL PROGRAMS AND EARLY IDENTIFICATION OF PROBLEMS.**
- 4. A FOLLOW-UP STUDY NEEDS TO BE DONE ON THE NEEDS OF SELECTIVE SERVICE REJECTEEES SINCE IT IS QUITE APPARENT THAT A SUBSTANTIAL NUMBER OF REJECTEEES HAVE NO DIFFICULTIES IN MAKING A CIVILIAN ADJUSTMENT.**

Such a study would involve interviews with a sample of rejectees in areas of the state with the highest rejection rates and would cost approximately \$5,000.

SINGLE DISABILITY TASK FORCE REPORTS

ALCOHOLIC

CEREBRAL PALSY

HEARING,

HEART, CANCER AND STROKE

MENTAL ILLNESS

MENTAL RETARDATION

PUBLIC OFFENDER

PULMONARY

In another section of this report there will be found material dealing with vocational rehabilitation problems of the aging. The task force report on rehabilitation of persons with visual difficulties has been prepared as a separate column because of its length and because the State's Commission for the Blind is responsible for the vocational rehabilitation of persons with visual impairments. In this section is a proposal prepared for the Task Force on Heart, Cancer and Stroke. The information in this proposal was taken from discussions that took place at the task force meetings and represents findings of the staff of the North Carolina Study in Vocational Rehabilitation. This task force, which was shared with the Regional Medical Program on Heart, Cancer and Stroke felt that the only concrete relationship between the Regional Medical Program and the Vocational Rehabilitation Program was an interest in the development of a comprehensive vocational rehabilitation center.

Report of the Task Force on Alcoholism

There have been two meetings of this task force. The first of these was held at North Carolina State University in Raleigh on August 31-September 1, 1967. The meeting was a general discussion meeting. Each member expressed his feelings about the total needs of the State as it relates to Vocational Rehabilitation.

A copy of the minutes was mailed to each individual member of the task force asking that he study same and be prepared for future meetings.

The second meeting of this task force was held in Greensboro at the office of the Alcohol Information Center, September 27, 1968.

Present at this meeting were the following individuals:

Alcoholic Rehabilitation Center	Butner, N. C.
Mr. Parks Goodnight	
Mr. W. W. Carroll	

Probation Department:	
Mr. George Pettigrew	Gastonia, N. C.
Mr. Charles Ross	Greenville, N. C.
Mr. R. L. Clayton	Winston-Salem, N. C.

Vocational Rehabilitation:	
Mr. Frank Mansfield	Charlotte, N. C.
Mr. Don Dunson	Durham, N. C.

Local Programs:	
Mr. Worth Williams	Greensboro, N. C.
Mr. Lantz Sykes	Greensboro, N. C.

Others:	
Mr. Banks Taylor	Maiden, N. C.
Clerk of Superior Court	
Mr. Lester Whitener	Gastonia, N. C.
Industrialist	

Absent were:	
Mr. Dave Merritt	Charlotte, N. C.
Mr. Pat Reece	Fayetteville, N. C.

The task force again had a general discussion and since the needs for alcohol education and alcoholism services is so great, it was decided that since there were so many areas in which vocational rehabilitation could fit into the total picture of alcohol problems that this report would attempt to pinpoint total needs for the State; with a feeling that vocational rehabilitation could help fill the needs in almost any of the departments or agencies mentioned in this report.

The following needs would be of a general nature:

1. Hospital beds should be available for treatment of the illness of alcoholism in every general hospital in our state.
2. More beds should be available in each state hospital so that daily admissions can be made and proper treatment be given more promptly than is being done at the present time.
3. There should be more comprehensive training for treatment of the illness of alcoholism in our medical schools, nursing schools (both RN and LPN) and theological seminaries.
4. There should be available a medical center in each of the 38 areas of the Mental Health Department. This center should provide emergency and in-patient services for each area.
5. In connection with the above-mentioned medical center, there should be an effective out-patient service for each area.
6. There should be a dormitory facility, a half-way house and/or sheltered workshop at strategic locations in many of our urban centers.

The following recommendations are made in the interest of specific departments of the state in an attempt to fill some of the needs of each department:

Vocational Rehabilitation:

1. There should be graduate schools for alcoholic counselors in the para-medical field.
2. There is great need for alcoholism specialists at the local level.
3. There is need for in-service training in alcoholism services.
4. It seems that there are State programs under the direction of Vocational Rehabilitation which are not extended to the local level; there should be better communication with the Vocational Rehabilitation Programs.

Probation:

As the district court programs are begun an alcoholism specialist should be assigned to each district court.

Department of Corrections:

There seems to be no uniformity by the courts in sentencing for public drunkenness under present laws. There should be guidelines from the director of the administration office of the courts to make sentencing uniform throughout the state.

The General Assembly directed the Department of Corrections to institute alcoholic rehabilitation programs in selected units. The General Assembly was then derelict in their responsibility by not providing sufficient funds to put effective programs in operation.

Mental Health:

The Division on Alcoholism in the Department of Mental Health is greatly undermanned and should be expanded to render greater services to local communities.

Alcohol Beverage Control Boards:

This committee recommends that the present laws allowing any ABC Boards to spend 5% of their profits for education, rehabilitation or research be changed to read that each local ABC Board must spend 5% of their profits for these purposes. Alcohol problems are in each local community and any effective results toward help with these problems must be done at the local level.

General Assembly:

The revenue to the State from the sale of alcoholic beverages exceeds thirty-one million dollars per year. In addition to the 5 cent per bottle price increase that was used to build rehabilitation centers has become a part of General Fund. This committee recommends that a large portion of this alcohol beverage revenue be allocated for alcoholism purposes in an effective program to fill the needs of the citizens of North Carolina in the area of alcohol problems.

A CRYING NEED:

At present there are many departments and agencies within the state who have an interest in alcohol problems. There is such a proliferation of agencies who have this interest that there is no effective communication among agencies as to what each of them is doing. Therefore, this committee strongly recommends that the Governor or the General Assembly create a central clearing house such as a Commission or a Foundation, with adequate funding so that this group could act as the coordinating body to communicate with and offer direction to each state department or local agency that has an interest in alcohol problems.

The feeling of many of the members of this committee is that the individual and/or family which has alcoholism has been sadly neglected by our General Assembly and the various State Departments. The state legalizes the sale of alcoholic beverages, receives tremendous revenue from such sales; therefore, a greater portion of these revenues should be used to alleviate alcohol problems. A central clearing house could do much to make effective use of the funds which the General Assembly should provide.

Comment:

It has been suggested that the recommendation concerning the Department of Corrections creating a uniform sentencing policy could best be handled through the office of the state's Attorney General or possibly the Institute of Government.

Report of Task Force on Cerebral Palsy

First, may we say that various agencies concerned with cerebral palsy have indicated a good rapport with the Division of Vocational Rehabilitation.

As far as we have been able to determine from various estimates and several surveys in North Carolina, there are about 16,000 persons afflicted with this condition. Perhaps fifty percent of these are mentally retarded to some degree.

We make the following general recommendations:

1. We believe there is a need to increase rehabilitation services of all types for these individuals at a much earlier age than 16. We believe this will result in more of these people becoming amenable to the regular services of vocational rehabilitation as they reach 16 and older.
2. We believe that the public schools can do more in the adjustment of physical facilities and of educational programs for the cerebral palsied.
3. We suggest that the Division of Vocational Rehabilitation examine with the intent of improvement of its programs of training, job placement and particularly follow-up with the employee and the employer.
4. We suggest that the Division investigate the program of small business enterprises developed by United Cerebral Palsy of New York City.

SUMMARY OF REPORT OF TASK FORCE ON HEARING DISABILITIES

Two meetings of the Task Force on Hearing Disabilities were held: the first on August 2, 1968, in Charlotte, North Carolina; the second on October 15, 1968, in Greensboro, North Carolina. Subcommittees were appointed to study in depth all phases of habilitation and rehabilitation of the hearing impaired population in North Carolina.

The avowed purpose of the Task Force on Hearing Disabilities of the North Carolina Study in Vocational Rehabilitation is to survey the extent of the problem of hearing disability in North Carolina, to examine the currently available programs, and to make recommendations regarding a comprehensive program of habilitation and rehabilitation to those disabled by virtue of hearing impairment. This purpose is in keeping with the desire to develop the maximum in human potential and create productive citizens in North Carolina, who can take their place in society as well-adjusted, self-sustaining, individuals. This Task Force shall concern itself with the over-all conservation, development and/or rehabilitation of those individuals impaired by loss of hearing, regardless of age, cause, or section of the state in which the individual resides.

For the purpose of this Task Force, a hearing impairment is defined as any loss of hearing which inhibits the normal reception and production of speech and inhibits the normal development of speech and language.

It is the committee's unanimous recommendation that a central coordinating council be established in North Carolina in order to publicize to the local level the existing resources and procedure to follow in order to best benefit from these resources. The council, in addition, should function in the following ways:

1. Develop a registry for the hearing impaired of this state.
2. Assimilate all information from all agencies concerning the hearing impaired in North Carolina.
3. Disseminate information concerned with the hearing impaired to agencies, groups, or individuals needing such information.
4. Coordinate all agencies within the state serving hearing impaired and develop within these agencies local volunteer groups to assist in various areas with the hearing impaired such as identification and routine screening, and publicity. An effort should be made to interest young people in seeking professional training in the field of the education of the deaf and hard-of-hearing.
5. Serve as liaison between individuals, groups and agencies.

Summary of Sub-Committee Recommendations

I. Case Findings, Diagnosis, Treatment, and Prevention

- A. Provisions should be made for the establishment of a statewide hearing conservation program giving responsibility for such a program to a state agency in order that it would be comprehensive.

- B. Mobile units should be provided in several areas of the state equipped with trained personnel who would administer specialized tests and make proper referrals to a certified audiologist and otologist for diagnosis, treatment and prevention.
- C. Immediately following identification and treatment, individuals should be referred to the coordinating council and to the individual agency that is to become involved with the habilitation or rehabilitation of the individual.
- D. Noise studies conducted in certain industries having high risk noise potential should be the responsibility of the state and a program should be developed with these industries to prevent hearing losses occurring by noise induced environments.

II. Parent Counseling

- A. Services of social workers on the staff of Vocational Rehabilitation and the schools for the deaf should be maintained and increased.
- B. Parent institutes should be conducted for the purpose of educating parents as to the development, adjustment, and limitations of the hearing impaired child—academically, socially, and psychologically.

III. Pre-School Training

- A. State and federal funds should be provided to establish day pre-schools to insure financial stability and support; thus children from all economic levels would be provided the same opportunity for educational and vocational potential.
- B. Responsibility for the education of hearing impaired children of less than five years of age should be vested in an authority having statewide jurisdiction. Minimum standards should be established by this authority concerning:
 - 1. Curriculum guidelines, qualifications and certification of faculty, and physical facilities for the pre-schools for hearing impaired children;
 - 2. The provision of complete medical, otological, audiological, and psychological evaluations prior to entrance into any pre-school program;
 - 3. The ratio of six children to one teacher and one teacher aid for the hearing impaired child;
 - 4. Minimum requirements regarding the facilities, equipment and supplies to at least equal the present preparatory classes in the state residential schools for the deaf.
- C. Necessary staff of qualified personnel should be provided for this authority to coordinate and supervise all pre-school programs.
- D. Colleges and universities should be encouraged to affiliate with these programs in order to train professional personnel in the area of hearing impairment.

IV. Schools (Elementary, Secondary and Vocational Training)

- A. The state should provide funds to the department of education in order to establish special classes in public schools as needed to educate the hard-of-hearing or the moderately hearing impaired child.
 - 1. Classroom facilities for hard-of-hearing children should, at minimum, be equal to those now provided for them at the state residential schools for the deaf.
 - 2. Minimum standards should be established by the department of education concerning curriculum guidelines, qualifications and certification of teachers, and selection of students to participate in this program.

3. Standards should be established in order to deny the enrollment of a deaf child into this program (this would be designed for the hard-of-hearing who could function in the public school setting—NOT for the moderately severe or severely hearing impaired child).
 4. The state should appropriate a realistic budget so that these programs can operate on a sound educational level.
- B. The state should increase finances, services, and state residential facilities in order to continue the education of moderately severe and severely hearing impaired children from five to twenty-one years of age as needed, both academically and vocationally.
 - C. Joint programs should be established in order to suitably place the multiply-handicapped hearing impaired child.
 - D. The state should continue, and improve pre-vocational and vocational training in the residential schools for the deaf.

V. Adult Education and Job Placement

- A. A central vocational facility should be established for the hearing impaired of North Carolina for habilitation and rehabilitation.
- B. Funds should be continued to assist in higher education of moderately severe and severely hearing impaired students in facilities now in existence throughout the United States.
- C. A program should be established to support educational training for hard-of-hearing students of North Carolina after high school graduation. Provisions should be made for advanced academic training for our own hard-of-hearing students who are not able to receive higher education at a regular college or university due to their hearing impairment.
- D. More Vocational Rehabilitation counselors are needed in order to continue efforts toward training and job placement for the adult deaf in an acceptable way.
- E. Funds should be provided for a centralized statewide publicity campaign in an effort to interest industry in the employment of hearing impaired individuals.

VI. Teacher Training Program for Professional Staff

- A. Funds should be provided by the state to colleges or universities in affiliation with state programs for hearing impaired for the training of professional staff so that the needs of the deaf and hard-of-hearing in North Carolina may be met.
- B. Professional staff should include:
 1. teachers for the deaf,
 2. teachers for the hard-of-hearing,
 3. psychologists,
 4. audiologists,
 5. administrators,
 6. social workers,
 7. counselors, and
 8. houseparents.
- C. Salaries should be increased to the national average in order to retain professional personnel and to attract teachers to the profession.

- D. The state should allow positions for qualified staff to meet the needs of existing and planned programs for the hearing impaired and provide funds for the training of professional staff in this profession.

VII. Publicity

- A. The statewide coordinating council should be responsible for statewide publicity relating to activities concerning the hearing impaired in this state. This should be accomplished by the following means:
 - 1. Spot announcements on both radio and television;
 - 2. Taped and/or live interviews with knowledgeable persons;
 - 3. Editorials and columns in local newspapers;
 - 4. Pamphlets, brochures and posters to be distributed throughout the state.

VIII. Availability of Agency Resources

- A. The coordinating council should familiarize itself with state and national available resources and prepare and distribute such upon request.
- B. The overlapping and duplication of services among various agencies should be redesigned in order to eliminate confusion and repetition. Agencies which have age overlaps or duplication of efforts appear to be:
 - 1. Head Start and Crippled Children's Section;
 - 2. Crippled Children's Section, Vocational Rehabilitation, Elementary and Secondary Education Act, and school health funds.

FULL REPORT OF TASK
FORCE ON HEARING DISABILITIES

Task Force on Hearing Disabilities of the North Carolina Study in Vocational Rehabilitation

PURPOSE:

The avowed purpose of the Task Force on hearing disabilities of the North Carolina Study in Vocational Rehabilitation is to survey the extent of the problem of hearing disability in North Carolina, to examine the currently available programs, and to make recommendations regarding a comprehensive program of habilitation and rehabilitation to those disabled by virtue of hearing impairment. This purpose is in keeping with the desire to develop the maximum in human potential and create productive citizens in North Carolina, who can take their place in society as well-adjusted, self-sustaining, individuals. This Task Force shall concern itself with the over-all conservation, development and/or rehabilitation of those individuals impaired by loss of hearing, regardless of age, cause, or section of the state in which the individual resides.

For the purpose of this Task Force, a hearing impairment is defined as any loss of hearing which inhibits the normal reception and production of speech and inhibits the normal development of speech and language.

The specific goals of this Task Force include: the identification, diagnosis, and treatment of individuals with hearing impairment; pre-school, elementary school, high school, vocational training, and higher education of these individuals; adult education and job placement; training of professional workers in the areas of clinical service, education, and guidance and counseling for individuals impaired by loss of hearing; public awareness of the extent and particular problems caused by loss of hearing; education of the public regarding possible causes of hearing impairment and preventive measures; and a survey of current programs, with recommendations for additional programs to provide appropriate and adequate services for the hearing impaired in North Carolina. The recommendations of this Task Force should, furthermore, be compatible with, and seek the cooperation of, other professional organizations and individuals, governmental agencies, public school systems, colleges and universities, vocational and technical schools, and industry.

TASK FORCE SUB-COMMITTEE
"CASE FINDINGS, DIAGNOSIS, TREATMENT, AND PREVENTION"
OCTOBER 30, 1968

The following report is submitted to be included in a comprehensive and innovative planning program for the hearing impaired of all ages in this State.

Public education is seen as a necessary prerequisite if this State is to deal with the topics, "Case Findings, Diagnosis, Treatment, and Prevention." It is necessary that the professionals in allied areas, as well as the general public, be made aware of the problems of hearing loss and deafness and the knowledge of what can be offered in the way of case findings, diagnosis, treatment and prevention.

State legislation must be enacted requiring a consistent, state-wide program for the identification of hearing problems; none exists at the present time. Included in the legislation should be detailed procedures outlining responsibilities of the various state departments which might participate, i.e. the Department of Public Instruction, Public Health, etc. It is recommended that persons qualified and certified in the areas of hearing testing and hearing problems (as clinical audiologists) be responsible for directing such a program. This may best be accomplished by dividing the State into 11 districts, each being served by a mobile unit and trained teams which could be moved across the State and complete hearing screening tests on those of all ages. The need for repeated screening and follow-up of all recommendations is stressed as being equally important. The referral system should include examinations by the family physician and/or an otologist and if indicated, a speech and hearing center.

The feasibility of the establishment of a state-wide Registry of hearing loss to be kept at some central point should be studied and perhaps included in this legislation. Referrals to the Registry might be limited to those cases having been diagnosed by professional people in the area of hearing.

It is recommended that a State program of Public Education using all mass media be established and executed by professionals in the field of public relation and/or education.

Diagnosis and treatment cannot be divorced from case findings, especially in neonates. Identification should be completed as early as possible. Some effort should be made to determine if hearing loss exists, then the type and at least the relative amount of hearing loss. If a conductive hearing loss is found, then medical treatment should be initiated; if sensorineural, then habilitative and educational intervention should begin as soon as possible. Again, education is stressed for the family of those with hearing loss as well as for professionals. The education programs should again be state-wide and consistent in nature.

The use of public and residential school facilities for summer programs for the hard of hearing and deaf is recommended.

In order to receive the proper diagnosis and treatment, it is felt a series of facilities might be needed and a specific "routing" of cases will be necessary. Screening programs can refer to otologists and then to smaller speech and hearing centers. Regional speech and hearing (and/or) rehabilitation centers, as might be found in teaching universities, medical schools or larger metropolitan areas, can be further developed for the most difficult cases but primarily for teaching and research. It is from the centers that the trained professionals might come. (It is estimated by 1970 there will be 8000 more professionals needed over the nation than will be trained by that time.)

The geriatric patient with a hearing loss should not be overlooked among those who should receive the proper diagnosis and treatment. Only the otologist can make the proper diagnosis and the speech and hearing center provide the proper rehabilitative steps necessary.

Early medical and educational referrals are necessary in the case of the young child. Prevention at its best may be seen in the work with children. The state-wide education program mentioned previously

should try to develop an awareness of the causes of hearing loss and instill the idea that positive measures can be made in the prevention of hearing loss.

Industry should be challenged and enlisted in a program for the prevention of noise induced hearing loss. Noise studies should be carried out in many industries and preventative and corrective measures taken. Hearing evaluations should be part of the pre-employment physical as well as an ongoing testing program in "high-risk" industries. Vocational counselors should continue to work with industry in the employment and reemployment of those with hearing losses.

It is felt the otologist, the personnel of the speech and hearing centers, the Schools for the Deaf and the State Department of Special Education would cooperate and make themselves available for consultation, workshops, etc. in an effort to assist in this imperative task of public education.

RECOMMENDATIONS:

1. Legislation to provide for a state-wide hearing conservation program, giving responsibility for such a program to a state agency or agencies in order that it would be comprehensive. Mobile units might be provided with personnel who could give specialized tests and appropriate referrals through the various speech and hearing hierarchy.
2. That an advisory commission be appointed for hearing impaired. Under this comes a Director of Public Education.
3. Enlistment of industry in a program of prevention of noise-induced hearing loss.

BY: Donald F. Bynum, Chairman
Task Force Sub-Committee

SUB-COMMITTEE MEMBERS:

Mr. Frank Saunders	Mr. Burton King
Dr. Henry Smith	Dr. Calvin Knobloch
Mr. Neal Smith	Dr. Robert O'Connor
Dr. Grady Thomas	Dr. B. R. Olinger

APPENDIX I

PURPOSE:

This meeting of the subcommittee was held to study the feasibility of expanding services for the hearing impaired through the employment of personnel and the purchasing of mobile units.

PRESENT:

Dr. Grady Thomas—Speech and Hearing Clinic, Chapel Hill
Dr. Calvin Knobloch—Speech and Hearing Clinic, VA Hospital, Durham
Mr. Burton King—Speech and Hearing Clinic, Duke University, Durham
Mr. Neal Smith—Speech and Hearing, State Department of Public Instruction, Raleigh

ABSTRACT OF MEETING:

After maps and projected school populations of the entire State were studied, it was decided that mobile units for providing services for the hearing impaired would be very feasible. A central State agency such as the Speech and Hearing Section of the State Department of Public Instruction could be provided funds for the purchasing of eleven mobile units and the employment of a professional and a sub-professional to operate each unit. The administration of the program, such as personnel scheduling and the maintenance of the units, could be provided by the State agency.

These units would provide:

- Screening for hearing impairments
- Evaluating and diagnosing
- Specialized therapy or instruction
- Counseling for school administrators, nurses (public health and school), parents and therapists
- In-service training
- Liaison for nurses, therapists and specialists in the Speech and Hearing Clinics
- Increase efficiency of referrals

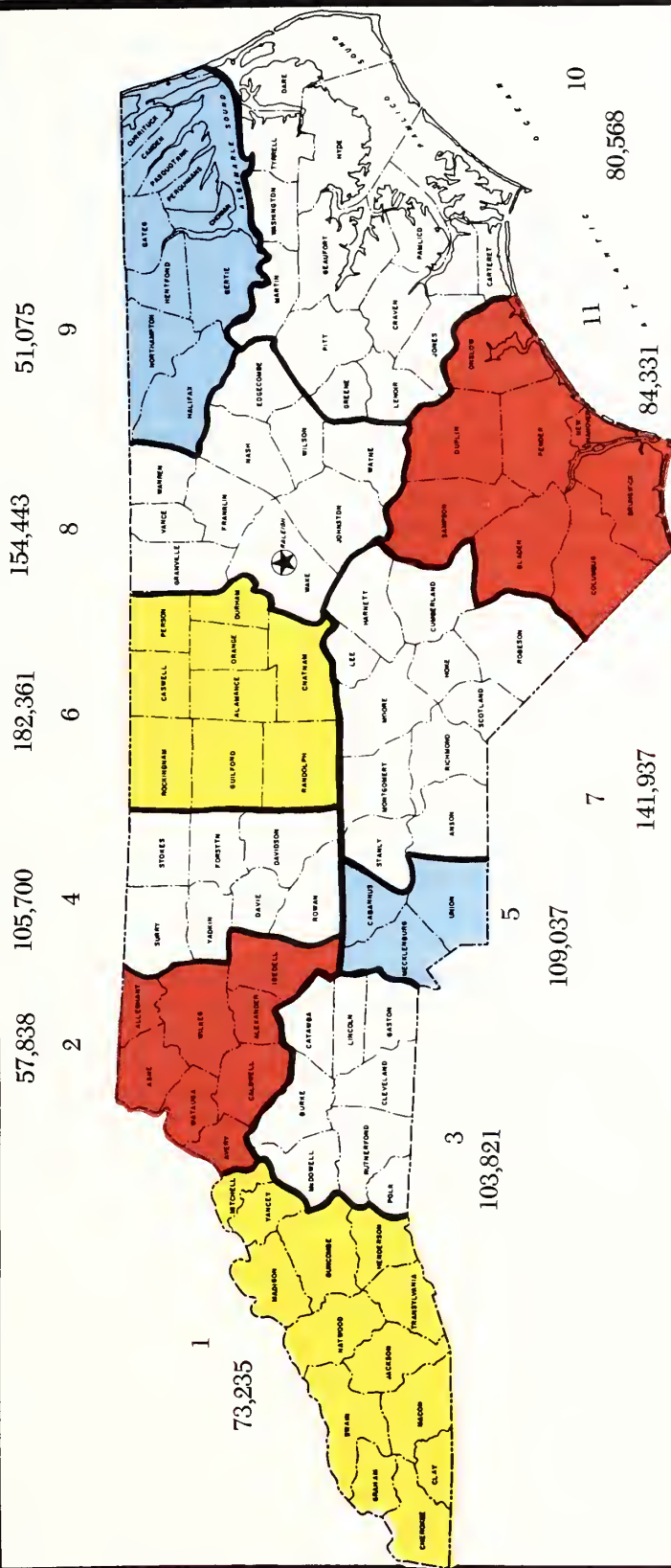
COST OF PROJECT:

The cost of this project would be approximately \$20,000 per unit with personnel employed on the regular State salary range. The salary would be determined by qualifications and experience of the individual. The increase in individual productivity and capability of the hearing impaired would more than compensate for the cost of the program.

RECOMMENDATION:

It is recommended that funds be provided for the purchasing of eleven mobile units and the employment of qualified personnel for their operation.

Figure 8



Proposed Divisions, Hearing and Visual Screening

The specific incidence of hearing impairment is difficult to isolate because of inadequate reporting of audiometric data, varying methods of testing, and a lack of public concern about hearing problems. However, public health authorities consistently report that defective hearing is the most common physical impairment in the nation today. In estimating the number of children with hearing impairments, one must state that some hearing losses may not be medically significant but can still interfere with the learning process. Such interference may often be of a transitory nature. Many authorities agree that approximately five per cent of our school population will have a "medically significant" hearing impairment. The projected school population in North Carolina for 1968-69 is approximately 1,193,267.

The State Department of Public Instruction is charged by the Public School Laws of North Carolina, Article 24, Section 115-200, with the organization and administration of "a program of special courses of instruction for handicapped, crippled, and other classes of individuals requiring special types of instruction." It is hoped, therefore, that the Speech and Hearing agency of the Special Education Section will be responsible for the public school programs for hearing impaired children recommended below. The use of this existing agency would eliminate the necessity for a separate coordinating arm at the state level. In addition, programs for hearing impaired children already initiated by the Department of Public Instruction are under the supervision of Special Education Speech and Hearing personnel. Thus, the machinery for implementing the suggestions below already exists.

The initiation of a complete public school program for hearing impaired children, beginning with age three years or younger, is recommended. Such a program would include:

I. *A State-wide hearing screening program should be initiated*

- A. Such a project would require the cooperation of agencies of the State Department of Health, the State schools for the deaf, local school units, and speech and hearing clinics.
- B. Mobile units could be utilized to test hearing in specific regions of the State (see Appendices A and B).

II. *Pre-school programs*

The State Department of Public Instruction now sponsors five classes in two areas of the State, and a need exists for funding five additional programs for pre-school hearing impaired.

III. *Programs for hearing impaired*

The enrollment of hearing impaired children in regular classrooms as soon as possible should be the goal of a program for hearing impaired children. Resource room and/or itinerant hearing therapists could provide supportive assistance. The extension of public school services to hearing impaired children through all grade levels so that full advantage may be taken of the vocational training and guidance available through regular public school programs. These services should be extended to all hearing impaired children who can demonstrate progress in such a program. No educational opportunity should be withheld from any child on the basis of the amount of his residual hearing, and his placement should be dictated only by his performance and capabilities.

In addition, the Special Education Speech and Hearing personnel would be responsible for:

1. Assisting local units in the planning and establishment of programs for hearing impaired children.
2. Dissemination of information regarding speech and hearing services and programs in North Carolina.
3. Parent counseling regarding available services.
4. Coordination with the State Public Health Authorities, Vocational Rehabilitation Services, State Residential Schools, and various Speech and Hearing Clinics in providing a complete program.

5. A central registry of all identified hearing impaired children in the State.
 - a. Such a registry would provide names of children who will require special services, to the appropriate programs.
 - b. The registry could follow progress of specific children until they are dismissed or transferred out of the North Carolina System.
 - c. Such a registry would help standardize available audiometric information and could facilitate transferring from one program to another within the State.
6. The certification requirements and qualifications of teacher-therapist personnel.
7. The implementation of suitable curricula in all public school programs for hearing impaired. The curricula would be devised with the assistance of nationally recognized authorities in education of the deaf.
8. Advisement of local educational agencies in the location and equipping of suitable classroom sites.

It is expected that, while obtaining qualified personnel would be a problem, such personnel could be recruited. There are five institutions of higher learning in the State which offer programs in speech and hearing therapy, and two which offer courses in education of the deaf. In addition, three neighboring states offer similar programs. Provisions for extensive in-service training should be made for teachers and teacher-aides.

It is not reasonable to expect that a complete program of the magnitude described here can be fully operational in one year or two. However, some immediate implementation could be begun this year if funds are made available. The remainder of the program could be planned for sequential initiation over the next five years. Such a State-wide plan would be costly, but the end result—hearing impaired adults who are contributing members of their communities—will more than justify cost.

Barbara A. Hanners

Addison Neal Smith

Figure 9

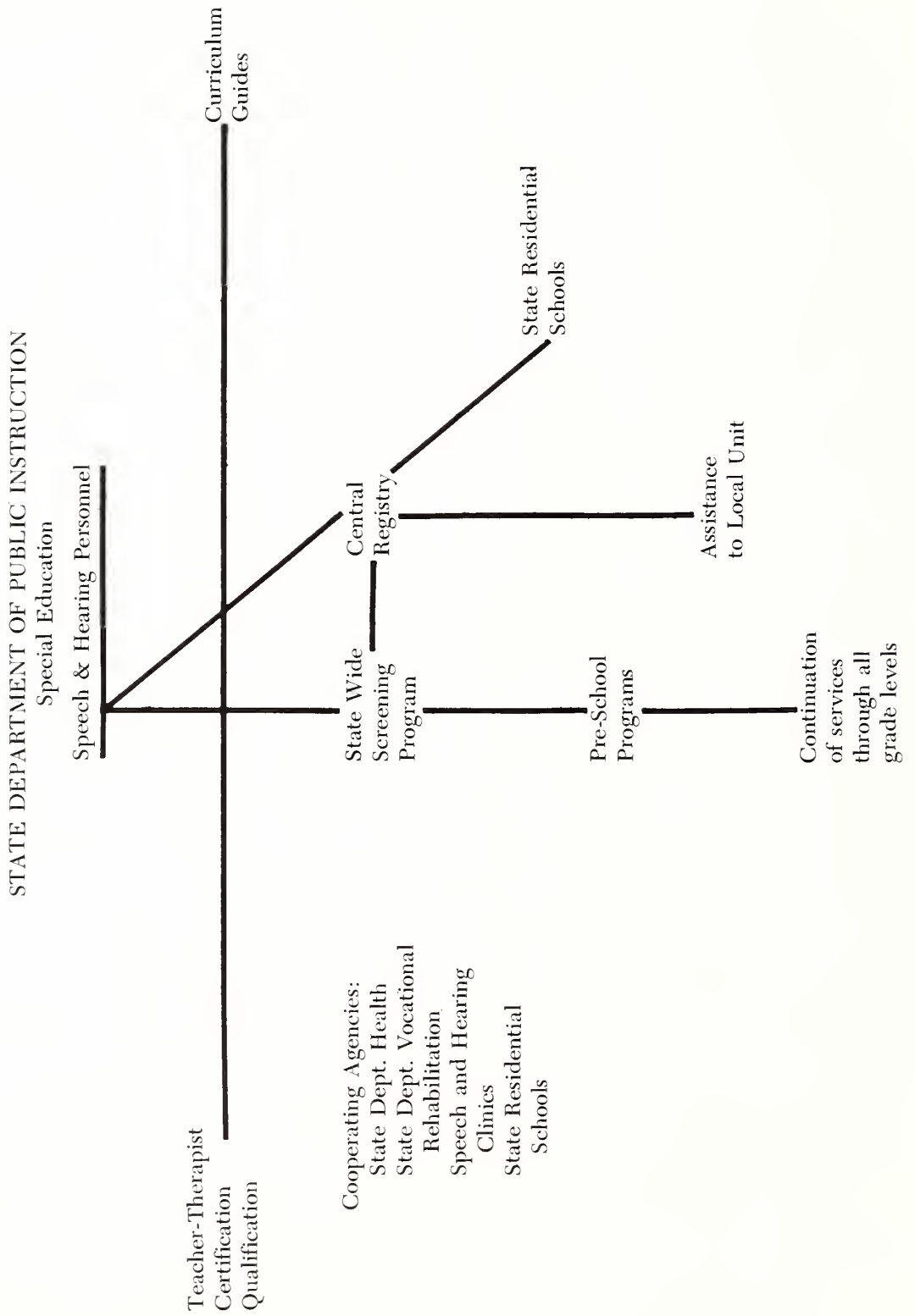
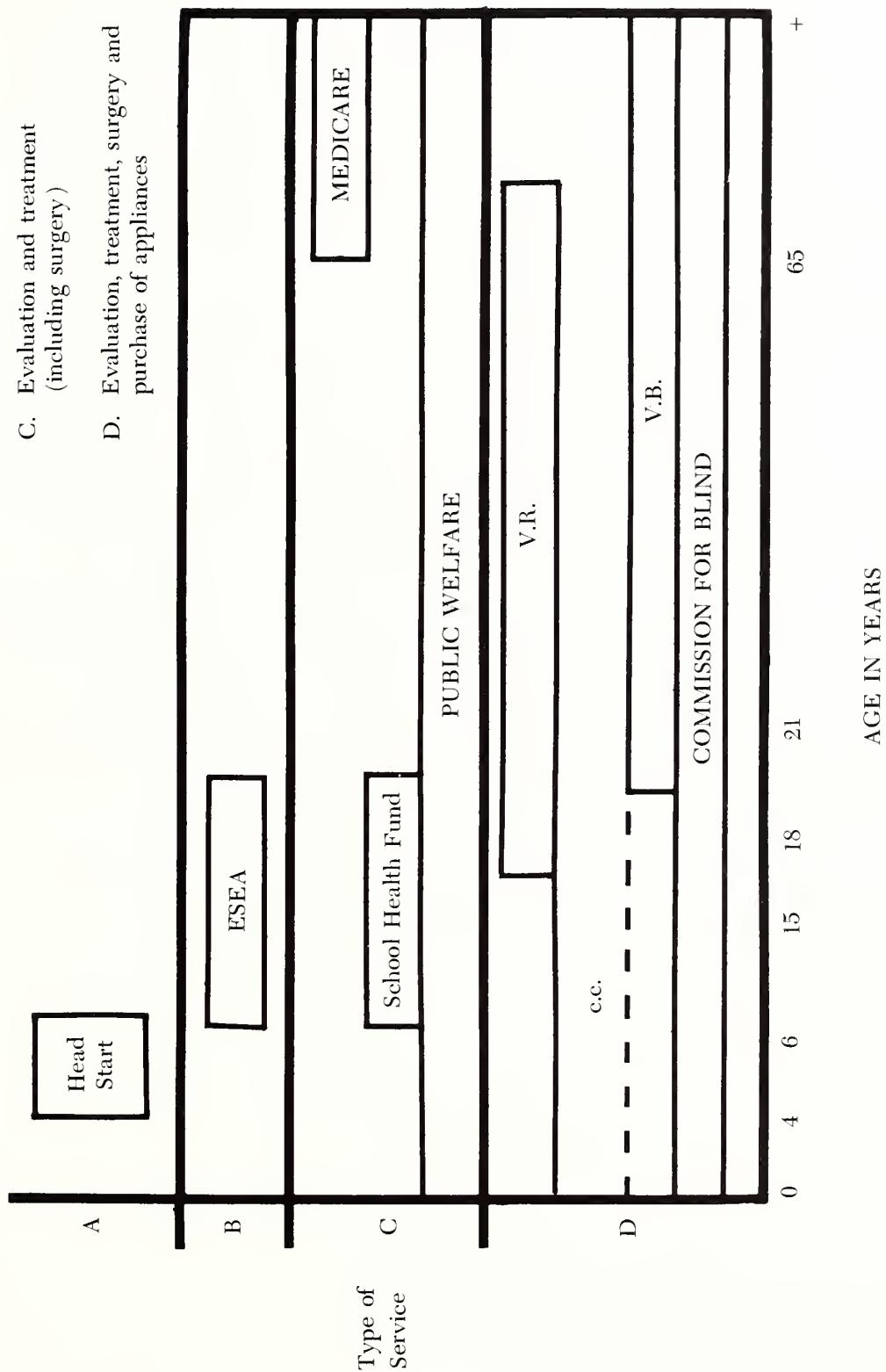


Figure 10

- A. Evaluation and treatment only
- B. Evaluation, treatment and purchase of appliances
- C. Evaluation and treatment (including surgery)
- D. Evaluation, treatment, surgery and purchase of appliances



Parent Counseling

It is well known that throughout the years when a person loses his hearing or a parent becomes aware that they have a child with a hearing loss that there is no place to turn for information. Therefore, we need to set up some organized bureau of information whereby a person with a hearing loss, or a parent having a child with a hearing loss may seek and find information consisting of the following:

- (1) E.N.T. Clinics
- (2) Pre-schools
- (3) State schools
- (4) V. R. Offices
- (5) Other parents or persons with the same handicap or problem.
- (6) H. & S. Clinics

These recommendations are being made to the North Carolina Study Group with the hope that some of the recommendations will be put into operation.

- I. Have a central point set up in the state where files can be kept on all referrals from all agencies or individuals.
 - a. Have a card file of name, age, address and parents' name and address.
 - b. When these referrals are received they will be sent to the proper agency or school.
- II. Maintain a Social Worker on the Staff of Vocational Rehabilitation and both schools for the deaf.
 - a. When a person is referred to schools, the Social Worker will visit the parents of this individual and talk to them explaining the operation of the pre-schools in the state, state schools and E.N.T. Clinics.
 - b. Conduct a parent institute each summer for pre-school children at both schools for the deaf.
- III. Maintain a file of services available to the deaf and hard of hearing to be kept by towns and counties and made readily available to parents and interested persons.
- IV. Take advantage of any information or studies being made on parents of deaf children in compiling this information.

J. B. Leonard

PRE-SCHOOL TRAINING FOR THE HEARING IMPAIRED CHILD IN NORTH CAROLINA TASK FORCE ON HEARING DISABILITIES, N. C. STUDY ON REHABILITATION

Purpose

The purpose of pre-school training for the hearing impaired child is to provide him with an opportunity to utilize his residual hearing through amplification of sounds and speech, and to acquire and develop language and speech skills through an organized but flexible curriculum within a nursery school environment.

Since the hearing impaired child suffers from limited auditory perception, it follows that he will suffer also from limited or delayed speech and language development. If speech and language skills are not acquired at an early age, the child's emotional and social adjustment will be impeded. Furthermore, as the hearing impaired child matures his educational and vocational pursuits will be curtailed, if he has not acquired appropriate language skills. These language skills include speech, reading, and writing.

For this report, the term "pre-school" covers the span of years beginning at birth or as soon as hearing impairment has been identified, until age 6 years when mandatory local school district responsibility begins for the child. Public school education in a residential school for the deaf begins at 5 years of age. If the hearing impaired child is to develop language and speech skills, he must be provided an opportunity for such training at an early age. For this training to be effective, it should begin immediately after the hearing impairment is identified.

Thus, the need for pre-school training of the hearing impaired child is evident. The opportunity for this training should be provided for every child with a severe hearing impairment, who lives in North Carolina.

Origin and Growth

Investigation has revealed that the first effort toward the establishment of a pre-school training program for hearing impaired children in North Carolina was begun in the spring of 1963, when six children enrolled in the Acoustic Nursery, Division of Otolaryngology at Duke University Medical Center in Durham.

During 1967, four additional pre-schools for hearing impaired children were established: Gaston Oral School in Gastonia, February; Raleigh Pre-School in Raleigh, June; the PATH School in Greensboro, October; and the Charlotte Speech and Hearing Center pre-school.

The pre-schools in Gastonia, Greensboro and Raleigh evolved from the efforts of concerned and dedicated parents of hearing impaired children, who lived in the vicinity of these three cities. The pre-school at Duke University Medical Center was instigated by professional personnel, who were identifying hearing impaired youngsters weekly in a hearing clinic on a large ear, nose, and throat service in a hospital. The preschool in Charlotte resulted from the interests of an executive director in a new speech and hearing center, which was being established in a densely populated area of the state.

Although the five pre-schools have different origins, their purposes and goals are similar and in some cases the same. The schools employ professional personnel, who have academic training and experience in the areas of nursery and kindergarten education, education of the deaf, and audiology and speech pathology. Four of the schools are organized as non-profit corporations and are governed by their boards of directors.

In the summer of 1968, two schools were incorporated into the independent school districts, within which their pupils lived. The Gaston Oral School was brought under the jurisdiction of the Special Education Department of the Gastonia public schools. The Raleigh Pre-school became part of the public school system of Wake County. These two schools are financed through Title VI public school funds.

Since their establishment, the five pre-schools for hearing impaired children have expanded their enrollment, curriculum, and faculty. At this writing, each school is serving the following number of children:

Charlotte Pre-school	26
Duke Acoustic Nursery	28 (20 additional seen individually)
Gaston Oral School	16
PATH School, Greensboro	18
Wake County Pre-school	12

Evaluation and Recommendations

Following the direction of Mr. McAdams, the Task Force Chairman, the committee on pre-school training has made a brief study of the 5 pre-schools for hearing impaired children in the State and made the following recommendations for action.

1. Prior to entrance into a pre-school for the hearing impaired, each child must have a complete medical, otological, and audiological evaluation to determine hearing impairment.

Since a lack of auditory response may be due to emotional disturbance, mental retardation, neurological damage, as well as hearing impairment, each child should be examined by professional specialists acquainted with these disorders.

2. Pediatricians and otolaryngologists should be informed by the Task Force of the problems and ramifications of hearing impairment. Specifically, they should be alerted to the importance of early diagnosis of hearing impairment and notified of the availability of clinical services and educational opportunities for the hearing impaired child.

It is a fallacy to assume that all physicians in the state are acquainted with the characteristics of hearing impairment in the young child. When pediatricians and otolaryngologists are made aware of clinical services and educational opportunities available for the deaf child, case findings and efficient referral to pre-school facilities will be greatly enhanced.

3. Pre-schools should be established in the densely populated areas of the state where the incidence of hearing impairment is greatest.

If learning is to take place, classes should be kept small and kept under control by 1 teacher. Because of the children's receptive language impairment, instructing them becomes a difficult task. A teacher should be expected to teach no more than 6 deaf youngsters at a time.

The 5 pre-schools in the state are located in Charlotte, Durham, Gastonia, Greensboro, and Raleigh. There are vast areas in the state in need of pre-school facilities for the hearing impaired.

4. The ratio for pre-school classes of hearing impaired children should be 6 children, to 1 teacher and 1 teacher aide.
5. Classroom facilities for the hearing impaired child should be equal to those provided for other children of nursery school age.

Although these children are deaf, they should be provided adequate floor space, good lighting, furniture of appropriate size, rest room facilities, and adequate classroom supplies commensurate to their educational needs.

6. Instrumentation of high quality and durability should be provided all pre-schools for the amplification of speech and sound signals.

For the hearing impaired child to become aware of a sound filled world, sounds and speech must be amplified for him.

7. Minimum standards should be established by an authority having statewide jurisdiction concerning curriculum guidelines, qualification and certification of faculty, and physical facilities for the pre-schools for hearing impaired children.

A committee or commission composed of educators of the deaf, professionals in audiology and speech pathology, pediatric psychology, pediatric medicine, and nursery school education should be established to carry out the above recommendation.

8. Pre-schools for hearing impaired children should be utilized by colleges and universities as laboratory schools for teachers in deaf education training programs.

Student teachers interested in working with pre-school age deaf children should be provided an opportunity to observe and participate in such programs under appropriate supervision. This would improve the quality of existing training programs and could indirectly facilitate the recruiting of teachers of the pre-schools.

9. Responsibility for the education of hearing impaired children of less than 5 years of age should be invested in an authority having statewide jurisdiction.

This responsibility could be met by supporting the existing pre-school programs administered by the Special Education Division of the State Department of Public Instruction and/or through the educational programs administered by the two residential schools for the deaf in this state.

Local day care pre-schools should be established when the population warrants a class for hearing impaired children of pre-school age.

10. State and federal funds should be provided the pre-schools to insure fiscal stability and support. Thus, children from all economic levels would be provided the same opportunity for education and vocational potential.

Adequate fiscal support is needed to provide for long term planning, an adequate physical plant, and to secure a good professional faculty. At this writing, 3 of the 5 pre-schools are dependent upon tuition fees and donations from local organizations for their operating expenses. There is no assurance that this support will continue indefinitely.

ELEMENTARY, SECONDARY AND VOCATIONAL TRAINING OF CHILDREN WITH NON-FUNCTIONAL HEARING

Task Force on Hearing Disabilities North Carolina Study in Vocational Rehabilitation

In North Carolina, children having non-functional hearing have been educated since 1845 in state schools for the deaf. During this time, these schools have quite adequately served deaf and hard-of-hearing students for whom admission was sought.

Each year since the establishment of the first school for the deaf in North Carolina, the enrollment has increased in accordance with, or by a greater percentage than, the normal population growth. In 1964, state schools for the deaf had reached an enrollment of 731 students, making necessary the establishment of another school for the deaf in the eastern region of the state. By the time this new school opened its doors, the enrollment had already reached the capacity, and this fact has continued to be true throughout successive building stages. In 1967, the Legislature approved an expansion in both the Morganton and Wilson schools in order to accommodate the assimilation of Negro deaf students presently educated at the Governor Morehead School in Raleigh, since that school will no longer serve the deaf after 1970. When the expansion program is completed, the Wilson and Morganton schools will accommodate 1,040 students, the expected enrollment by 1970.

In addition, the Board of Directors of the North Carolina School for the Deaf has asked for a new vocational unit to be established so that adequate facilities will be ready for the additional one-hundred-fifty students from Governor Morehead School.

Enough cannot be said about the program recently launched jointly between the North Carolina School for the Deaf and the Division of Vocational Rehabilitation for the future educational picture of the deaf. It exemplifies the technical institute concept for the deaf inasmuch as it can offer post-school vocational training and adult vocational training.

It has been projected by the Board of Directors of the North Carolina Schools for the Deaf that the population of school-age deaf in our state will be more than 1,200 by 1972. To take care of this enrollment increase, the Board of Directors has asked for a new elementary school to be established in the central part of the state. This new facility will house 240 students. With these three residential facilities in operation as planned, it is felt that, so far as traditional school facilities are concerned, they will sufficiently serve the deaf of North Carolina.

The committee would like to emphasize the fact that the above statements describe provisions for only the deaf and a small percentage of the hard-of-hearing in our state . . . not for the total population of non-functional-hearing, school-age children who are known to exist. Financial considerations did not permit the expansion programs to be designed to accommodate numbers of additional students which may justifiably be anticipated from other than usual sources. Growth has been limited to being merely adequate to care for the deaf already enrolled in state programs. The system described above can serve only a believed 17% of the hearing impaired children within our borders.

In the past, due to the small population, age differences, and grade level differences among hard-of-hearing students in any one area, it has been necessary in a number of cases to accept these children at state institutions for the deaf because of their inability to succeed in a regular public school setting. Too many public school systems are not aware of the fact that state schools for the deaf, out of necessity, have classes for hard-of-hearing children. They have, therefore, sometimes placed these children in special education classes for the mentally retarded and/or have socially promoted them until the acute years of learning have passed. These children can frequently function in a hearing world with a minimum amount of special education, consisting in the majority of cases of a trained

teacher knowledgeable of the problems of the hard-of-hearing and an auditory training unit in the classroom.

A Joint Committee of the American Speech and Hearing Association and the Conference of Executives of the American Schools for the Deaf are in the process of surveying the number of hard-of-hearing school-age children there are in programs for the hard-of-hearing in the United States. It is estimated that approximately one out of every two hundred school-age children has a hearing loss ranging from 25-79 db. With the present school-age population in North Carolina being 1,218,500, this estimation would indicate that there are 6,093 students in North Carolina with hearing losses. It is the recommendation of the Conference of Executives that programs developed to take care of these children in the public school setting should, as a minimum, consist of forty students with a minimum of five well-graded classes. It was recommended that in addition to the one teacher to eight students ratio, there should be a full-time professionally trained supervisor for this program, above and beyond the local principal.

There are eighteen areas with populations of more than 50,000 people and we feel that there could be at least ten or more programs for the hard-of-hearing, strategically placed to population, where approximately 80% of the hard-of-hearing children could be bused to and from public school. With a program such as this we will have utilized facilities at the public school level with a minimal amount of added expense.

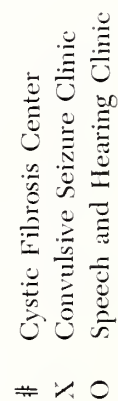
It is not feasible to educate hard-of-hearing children in the residential school for the deaf because of the difference in methods of teaching the deaf and the hard-of-hearing. Hard-of-hearing students need to associate with the normal population and it is more natural that they be taught in affiliation with the present public school program, where the majority of them will be able to continue living with their families.

In a mission such as the Task Force for Hearing Disabilities, one is tempted to elaborate on specific needs felt by existing agencies which are currently involved in the education of the hearing impaired child. Such a viewpoint might very well strengthen existing programs; but it would most certainly limit visions for future program development. In order to best meet the needs of all children with hearing disabilities and to reach the high percentage of unserved non-functional-hearing children in North Carolina, other agencies should be involved and their resources made available.

It is, therefore, the committee's recommendation that:

- (1) Facilities be established in the densely populated areas throughout North Carolina to educate the high percentage of hard-of-hearing students who are presently enrolled in the public school systems and are not receiving any form of special education. The population should be large enough to provide well-graded classes and professional trained teachers and supervisors. In less populated areas, a multi-county program is recommended.
 - (a) Classroom facilities for hard-of-hearing children should, at minimum, be equal to those now provided for them at the state residential schools for the deaf.
 - (b) Minimum standards should be established by an authority having statewide jurisdiction concerning curriculum guidelines, qualifications and certification of teachers, and selection of students to participate in the program.
 - (c) Prior to entrance into the special program for the hard-of-hearing, each student must have a complete audiological and otological evaluation to determine his eligibility.
 - (d) Standards should be established in order to deny the enrollment of a deaf child into this program. (This would be designed for the hard-of-hearing who could function in the public school setting, NOT for the deaf child.)
 - (e) A concerted effort should be made to establish more programs for teacher training teachers of the deaf and teachers of the hard-of-hearing. State certification should be established for a teacher of hard-of-hearing students.
- (2) Joint programs should be established with the state schools for the deaf and other agencies such as the Department of Public Instruction, the Commission for the Blind, the Department of Public Health, the Department of Public Welfare, the State Board of Education, and the State

Location of various clinics in North Carolina sponsored by the Crippled Children's Section of the State Board of Health



Board of Mental Health, in order to best serve the multiply handicapped, hearing impaired children whose needs are not being met.

For example, there is at the present time no vocational program in this state for the mentally retarded and/or emotionally disturbed deaf child who is unable to progress at a satisfactory rate in the state schools for the deaf. In too many cases this child is left at home with no formal or informal training. In order to have an effective program for this child in the state institutions for the deaf, it would be necessary to build new facilities; to create sheltered workshops, to offer short-term or long-term custodial care; to provide physical therapy, social services, and parent counseling; to secure extensive neurological, psychological, psychiatric, and medical services; and to support pre-vocational training experiences for this child so that he will be eligible to participate in vocational programs as he is able.

Considering these factors, it would be economically wise and therapeutically sound to establish a cooperative program with the educators of the deaf and another state agency, such as an institution for the mentally retarded, which already has these types of services. By initiating a program in such a setting and by participating in a joint program, all needs could be met for the mentally retarded and/or emotionally disturbed deaf child with a minimal amount of additional expense.

This example suggests a cooperative program with only the state schools for the deaf and the State Board of Mental Health. Other programs could be established which would need cooperation among different agencies.

- (3) That Vocational Rehabilitation expedite complete plans for the program which has been initiated this year in order that the goals and purposes may be realized as soon as possible.
- (4) That a program be established to support academic training of the deaf and hard-of-hearing students after high school graduation. There is only one liberal arts college for the deaf in the world, and with competition being greater and more numbers of hard-of-hearing students attending this facility, requirements for entrance cannot be met by all students needing higher education. Provisions should be made for advanced academic training for our own deaf and hard-of-hearing students who are not able to receive higher education at a regular college or university, or who would not meet entrance requirements at Gallaudet College.
- (5) Due to the increased cost of visual stimuli used in teaching the deaf and hard-of-hearing and the operation of necessary equipment such as the overhead projector, 8mm and 16mm projectors, filmstrips, etc., which have replaced the traditional blackboard and doubled the cost of operation, we would like to call attention to the financial aspects of operating an effective program for the deaf and hard-of-hearing students. Traditionally, we have been allotted \$8.19 per pupil expenditure for all academic supplies and materials. This was a realistic allotment in years past; however, due to the increased cost of supplies and materials, and the entirely new kinds of supplies and materials, it has become impossible to operate an effective program at the state residential schools for the deaf and will be impossible to operate an effective program in the public school system with an expenditure as low as this.

We, therefore, recommend that the existing programs and the programs hoped to be established in the public schools for the hard-of-hearing, and in other areas, have separate and realistic budgets so they may establish and maintain high standards for the education of these students.

The Board of Directors of the North Carolina Schools for the Deaf will continue to assume the responsibility of educating deaf children. However, it is hoped that the above recommendations will be met to strengthen existing programs and develop other programs which will meet the needs of children not being served at this time.

Respectfully submitted,

H. G. Royall, Jr., Chairman

COMMITTEE ON SCHOOLS (ELEMENTARY,
SECONDARY AND VOCATIONAL)

Dr. James C. White, Jr.

Mr. W. S. McCord

Mrs. Jane C. Williams

Mr. William Simpson

Task Force on Deafness

I ADULT EDUCATION

II JOB PLACEMENT

(I) Adult education provisions for deaf persons are virtually nonexistent in North Carolina, especially for those individuals who have been deprived an opportunity to obtain the barest rudiments of a formal education. There are hundreds of intelligent adult deaf individuals residing in all parts of the state who have been deaf since birth or an early age and have neither the ability to speak, read, write or even communicate in the simplest fundamentals of the language of signs. At the present time, also, there are hundreds of deaf children of school age who are not being sent to schools for the deaf—nor will they ever be. They are destined to grow up and eventually become wards of the State—with the exception of a small number, most will be welfare recipients, many will be “put away” and forgotten in the wards of our state hospitals. Here I speak of the intelligent deaf person—not those who suffer also from mental problems. Many deaf individuals who are intelligent do become mentally disturbed—lacking an education and means of communicating their desires to express themselves. This condition often leads to mental disturbances, criminal actions and other undesirables.

Ignorance on the part of parents and the reluctance of county education personnel to force the issue or provide counsel and advice, (most are completely ignorant of the problems of deafness) is the underlying cause of most education problems concerning the deaf child who is permitted to enter a public school class room while there exists fine state schools with trained personnel expressly for the purpose of educating the deaf child. Or even worse, the child is permitted to remain at home and attend no school at all.

Such gross neglect is far more prevalent than many of you here will want to admit. I doubt the seriousness of the situation is realized but by very few persons.

Remedial measures: (1) Stricter rules concerning the admission of deaf children into regular classes in public schools. (2) Compulsory education programs for all county school administrative personnel, County Welfare Directors, County Health Directors, requiring that they acquaint themselves with the special state schools and health and mental institutions. To acquaint means also to visit the institutions personally. (3) A centrally located facility with specially trained personnel to train and care for the uneducated intelligent adult deaf, and also the mentally disturbed.

It is estimated that about 90% of today's deaf adults (16 years of age and over) have an academic achievement below the 9th grade level. Many would prefer to continue or begin again—either or both—academic or vocational training. There is no place for them in public or private training centers. This group has no place to turn to pursue hopes for more and better training. Time and time again we draw a blank when inquiring of certain training centers as to the possibility of enrolling a deaf client. Finally there is no choice but to seek some menial job. This accounts for the fact that five-sixths of the deaf are in some form of menial labor as compared to one-half of the general population. (4) The state needs a Central Technical High School for the Deaf wherein the graduates of our state schools for the deaf may continue their training under appropriate conditions. This kind of institution has been too long in the planning stage, meanwhile allowing hundreds of our deaf youths to “go to waste”. (5) The Vocational Rehabilitation Facilities located in various State Hospitals should be staffed by trained personnel to look after the training needs of the trainable retarded deaf adult and child.

Should the State be unprepared for the quick action requiring facilities for public-supported education centers for intelligent deaf adults, it is suggested that these deaf persons be provided the opportunity to take full advantage of existing out-of-state facilities—namely the Hot Springs Rehabilitation Center, Hot Springs, Ark., Delgado Junior College, New Orleans, La. For higher education there are opportunities awaiting deaf men and women at Gallaudet College, Washington, D. C., National Technical Institute for the Deaf, Rochester, N. Y. Also the Lear Siegler Institute (IBM), Silver Springs, Md. More information on these existing training centers can be easily obtained.

Our existing state institutions for the deaf should not be used also as training centers for the deaf adult.

(II) JOB PLACEMENT

We shall not launch into any lengthy discussion on this topic. The academic achievement and/or job training largely determines the success in job placement to the intelligent adult deaf. The young man or woman with commendable academic success is not our concern. There are unlimited opportunities for this group. Those young adults with less success, academically but possessing special vocational skill are also of less concern. These groups are capable of plotting their own course with gentle guidance. Much too frequently, those in responsible positions, are prone to encourage dependency by offering too much help too freely in aiding their deaf "charge" over difficult courses, whereas this very course should have become a route along the "trail of education by Hard Knocks." This is one of the main reasons the schools fail to develop a "normal" number of leaders—which is what our state is at present in short supply of. Often, too, the aid given by the Vocational Rehabilitation Agency can do more "harm" than good—the Rehabilitation Counselor can easily become too helpful—thus creating dependency instead of the aim—INDEPENDENCE.

Job placement for the less educated vocationally trained deaf adult is an existing serious condition, not only in North Carolina—but in the whole nation. Further job training for the majority is virtually impossible. There are no places for them to go for re-training. The new industries moving into the state are highly mechanized with special training required of employees. Experiences show us that these corporations do not wish to "be bothered" with training the deaf. Their claims of problems of communication and safety measures will not permit the hiring of deaf workers—thus, too often the deaf person is forced to accept jobs below his or her intelligence and vocational capabilities.

Remedies? Special provisions for training of the deaf worker to meet the challenge of automation; a more vigorous campaign to persuade existing and new industries to give the deaf worker a chance to prove his worth. The first step toward accomplishing such a goal can be gained through a concentrated public relations program. The majority of the industry personnel do not know of the problems they create when they refuse employment to the deaf man and woman. They have not been educated. Thus, we who know, are to blame when we allow industry to be a part of our problem instead of a remedy.

It is suggested that the State Department of Labor be made aware of the problems the deaf encounter by being denied employment in a great many of the new industrial firms now being located in North Carolina. These firms should be required to make every effort to employ deaf men and women. There are few—if any—jobs that the deaf employee cannot perform as well as those possessing normal hearing. The main problem is persuading industry to permit the deaf an opportunity to prove their ability. The Labor Department should be permitted the power to compel and compelled to act.

The personnel office of most plants present a variety of "tactful excuses" as to why deaf employees are not permitted. Few, if any of their excuses are valid. They are feeble efforts at saying, "we don't wish to be bothered."

Suggested remedy: All industrial firms that cannot or do not hire the hearing handicapped should be required to present to the Labor Department a written statement on reasons for not hiring the hearing handicapped. The Labor Department should investigate and verify the validity of the reasons before they can deny deaf persons employment. Furthermore these statements of employment denials to be duly and permanently posted at the personnel office in clear view of prospective employees. To deny the deaf employment is DISCRIMINATION—as for race, color, creed.

COMMITTEE ON TRAINING OF PROFESSIONAL PERSONNEL

Participants:

M. S. Werner, Chairman
Burket Bergl
Ralph Causby
Dan Misenheimer
H. G. Royal
Winifred B. Shufelt

The Committee on Training of Professional Personnel met at the N. C. School for the Deaf at 10:00 A.M., Friday, October 11, 1968. Mrs. Bergl was hostess and was a gold-mine of information.

Initial discussions revolved about the long-range goals for education for the deaf in North Carolina. It was felt that there would not be sufficient difference between the training of teachers for day schools for the deaf and those for residential schools to warrant our immediate concern.

Four major problem areas were defined:

1. Teacher recruitment
2. Teacher training
3. Teacher retention
4. Teacher retrieval

Recommendations for teacher recruitment included spot-TV "commercials" of the non-profit service spot category, movies describing education of the deaf as a career. A V-R movie on the N. C. School for the Deaf is being prepared as a resource. Television programs on deaf education spin off useful recruiting materials. The value of the super-market poster "Are you a parent of a pre-school deaf child? Phone - ." was discussed with the recommendation of using such an approach to reach the interest of college-bound, high school students. Traineeships for teacher education are valuable, but require the back-up of better salaries, etc.

Recommendations for teacher training were mostly for the graduate curriculum. The group is content with the current undergraduate program, aside from the need for more student-teachers. Undergraduate work is currently offered through a cooperative arrangement with Lenoir-Rhine College, with 37 semester hours of practicum and audiology being given at the NCSD. The graduate program has had a shaky career at Appalachian Univ. There are prospects for its improvement. The graduate programs needed are:

1. Offer the undergrad. deaf-ed courses to out-of-field college grads on the grad level. (Appalachian)
2. Offer undergrad. and grad speech and hearing courses to BS teachers of the deaf. (in advanced planning stage at W.C.U.)

The desirability of the broader perspective of communication disorders to be found in the curriculum of the speech correctionist had been indicated earlier by NCSD Supt. Ben Hoffmeyer.

Recommendations for teacher retention were mostly concerned with salaries. It has been felt that there may be no shortage of teachers in Morganton, but that salaries at NCSD were not high enough

to compete with income tax savings realized by a husband keeping his teacher-wife at home. Mrs. Bergl agreed to run a cost analysis so as to lend muscle to salary discussions with legislators: It was felt that the traineeship rate on a per student-year cost basis may constitute a false economy to the State of North Carolina if graduates continue to depart the profession and/or area because of non-competitive salaries. It is proposed that this information be included in a letter drafted by the N. C. Task Force and sent to appropriate legislators.

Recommendations for teacher retrieval involve both salary increases and provision for part-time employment. It is felt that the return of trained teachers to the classroom on a part-time basis could be facilitated if the appropriate administrative or legislative body would provide machinery whereby professionally trained people could be employed on a part-time basis. For instance, an allotment of 10/10 of a teacher might permit a good rhythm person for 8 hours per week, a tool-and-die specialist 24 hours per week, and a computer programmer for 8 hours per week. Salary money has to be enough to make the effort worth one's while. Income taxes are a dominant competitor for full-time people. Transportation, food, and time constitute significant expenses for part-time people. Part-time people would therefore have to be paid on a somewhat higher hourly rate than would the full-time. The foregoing should be worked out relative to the cost of living in Morganton and Wilson, N. C., and the pay scales for positions elsewhere for persons with comparable education and experience.

Miscellaneous; With the rise in the number of paraprofessionals coming into deaf-ed and speech and hearing, it is recommended that a measure be decided upon for the number of years of practical experience such a person brings to school which might be accepted in lieu of practicum credit. It was felt that on the masters level, a teacher training program should include an emphasis upon creativity, breadth of experience with the multiple handicapped, and a research thesis. It was suggested that those M.S. candidates who have had the deaf-ed undergraduate program, have their graduate practicum in speech only (12 wks).

A program of teacher training for the deaf to affiliate with the Wilson School and with Atlantic Christian (undergrad.) and E. Carolina Univ., Greenville (grad.) Additional program someday at U.N.C.-G. Minimum standards for preparation of the hearing therapist (similar to speech therapist in public school) must be defined.

Marlin S. Werner, Chairman

PUBLICITY-PUBLIC EDUCATION COMMITTEE

1. Designation or appointment of full-time employee to supervise and coordinate programs of information and publicity on a year-round basis, thru use of Free Public Service time on radio and television. We should recognize that the value of any such program is on a continued saturation base. Recommend the above be implemented thru the following:

a. Spot announcements on both radio and television. Although each message would be relatively short and factual, the value is in the great frequency of hearing and seeing. The careful preparation of such materials by professionals is mandatory in order to be effective.

b. Taped and/or recorded interviews with knowledgeable persons be supplied to individual stations, after determining such stations needs for this material. Station contact by personal interview or postal questionnaire must precede such a program.

2. Similar contact to be made with Newspaper Editors, Columnists, and Reporters, emphasizing human interests, local involvement, and unusual aspects. Regular news releases concerning activities, personnel of schools and related programs.

3. Full use of Educational Television and Radio. This to include preparation and use of full-length programs, telling the story of the Deaf and the existing schools, programs, and aids available to them.

4. Through printed matter, pamphlets, posters, and billboards, if available, and enlistment of the Junior League and other various Garden and Civic Clubs to help expand and/or initiate programs to advise parents of Deaf or Partially Deaf Children, advising all the avenues available to them in helping to educate these children academically and socially, so they may become self-sufficient and take a normal place in our society.

5. That a complete reference library of cataloged audio-visual aids be established which will be available to interested groups and clubs. Such a library to include professional material as well as information.

AGENCY SUPPORT COMMITTEE ON HEARING DISABILITIES

The availability of support from agencies, associations, and private groups can conveniently be broken down into two categories: those offering financial support and those offering educational and counseling support. It is the task of this sub-committee to identify the kinds and amount of support available and to recommend possible changes to render this support more effective.

I. Current Support Available

A. *Financial*

1. *Federal and State*

- a) Crippled Children Section—State Board of Health: Services for speech and hearing defects are provided at seven centers¹ established in selected areas of the state. These centers are adequately staffed and equipped to diagnose, evaluate, and treat or recommend treatment for disorders of speech and/or hearing. Presentation is through appointment arranged by local physicians or health officers with the clinic coordinator. School children screened for these

¹See figure 11, page 92.

defects through the school health program are referred to the local health departments which arrange for appointments at the Centers.

Patients are evaluated by a group representing the disciplines of pediatrics, otology, and speech pathology with provision made for consultations in other disciplines. Speech therapy, essential appliances and prostheses, hospitalization and surgery when indicated are all arranged and requested at these centers.

This agency accepts individuals from birth to twenty-one (21) years of age for support, with eligibility for this support depending upon public welfare certification of annual net income falling below a maximum set by the Crippled Children's Section, according to the number of dependents in the family.

- b) School Health Fund: The School Health Fund supports clinical visits for diagnosis and treatment to needy school aged children. This fund is administered by local school authorities and is dependent upon availability of funds. This fund will support corrective surgery, in addition to clinical visits.
- c) Head Start Program: The Head Start Program (Section 2, OEA) provides financial support for clinical visits for the purpose of diagnosis and treatment of hearing impairment to children in their program.
- d) Public Welfare Department: Programs are geared to meet the needs of certain groups (commonly called categories) of people such as the aged, disabled, and dependent children. There are certain criteria for determining eligibility for help under these groupings.

The aged must be 65 or over, in need and must meet the budgetary standards. The disabled must have an impairment of major importance which is not likely to improve and which substantially precludes employment. He must be in need and between the age of 18-65. Disability determination is made by the Medical Review Team of the State Department of Public Welfare and is composed of a group of physicians. Dependent children must be deprived of parental support either because of the parent's disability or continued absence from the home. A child may be considered dependent up to the age of 18 if regularly attending school or 21 if enrolled in college.

- i. If a person with a hearing impairment meets the criteria for any of the groups mentioned, it is likely that he would be eligible for financial assistance.
- ii. Financial help is based on a standard budget with some variations, depending on actual circumstances of the individual involved.
- iii. Family income, if any, is balanced against needs when a budget is computed. Age under each category was explained earlier.
- iv. Help with medical expenses is available to those families receiving a monthly check and also to another broad group (eligibility also related to the groups or categories) who may receive help with medical care only (commonly called Vendor Payment Only). Under our Medical Services Program, outpatient clinic visits for diagnosis are covered. There are no limitations on diagnostic procedures. To the contrary we expect our recipients to receive the same care which the hospital provides to any other patient.
- v. Outpatient therapy is covered on the same basis as diagnosis. Public Welfare is not directly involved in a re-training program for hearing impaired persons, although our Social Workers at the local level help recipients with planning to use other resources in the community such as Vocational Rehabilitation.

- vi. Public Welfare excludes the purchase of appliances such as hearing aids from the Medical Services Program. When the need for such aids arises, we attempt to locate other resources.
 - vii. Hospital admission and surgical corrections for hearing impairments is covered under our inpatient program. For both recipients of money help and the Vendor Payment Only group, inpatient care is provided as long as medical need exists. We make no effort to limit inpatient care as to procedure (except for dental care only) or as to time. This is a decision which we feel can be made only by the physician who is responsible for his patient's treatment.
- e) **Elementary and Secondary Education Act (ESEA):** The Elementary and Secondary Education Act has many titles covering the range of school administration. Several titles are of specific interest to the hearing impaired. Title I funds are available to culturally deprived children and can be used to supplement educational programs, special programs (such as remedial reading, language, etc.), and provided needed programs for this group. Title III funds are available for special projects, mostly innovative, and can include consultation services. Fifteen percent (15%) of Title III funds are used for special education programs. Title IV funds can be used in any way for the handicapped. Basically, the funds are used to provide service which is currently not available. Emphasis is not placed on purchase of appliances for individuals, but, on purchase on special equipment. Clinical service for diagnosis can be contracted on these funds. Title XIX funds covers any child under welfare coverage for any need—medical, appliance, etc.
- ESEA funds are provided for projects submitted by local school units, except Title XIX which offers direct service.
- f) **Vocational Rehabilitation:** Eligibility: The North Carolina Division of Vocational Rehabilitation shall be the sole State Agency for the determination of eligibility of individuals for Vocational Rehabilitation services, except for those persons who are declared to be industrially blind. To be eligible a person must meet the following three basic requirements:
- i. The presence of a physical or mental disability.
 - ii. The existence of a substantial handicap to employment.
 - iii. A reasonable expectation that Vocational Rehabilitation services may render the individual fit to engage in a gainful occupation. "Gainful occupation" means any job in the competitive labor market, the practice of a profession, self-employment for which the payment is made in cash or kind, homemaking, farm, or family work, sheltered employment, and home industry or other homebound work of a remunerative nature.

Hearing Disabilities: Clients without prior work experience may be provided vocational training if the loss of hearing in the better ear is 30 decibels or more. If the loss in one ear is 100 percent, 10 decibels may be added to the better ear. Clients with work experience are eligible for training only if the loss of hearing is interfering with continued employment. In a few cases of neurosensory deafness, pure sound audiograms may show as little as 10-30 percent loss in both ears, but the client still cannot distinguish the sounds and, in effect, has, therefore, more than 10 percent functional loss. If such is present, the counselor should : (1) ascertain that the loss is bilateral, and (2) inquire as to whether a pure tone audiogram was used. A hearing aid is frequently of great value in these instances, but various types must be tried.

- g) **Veterans Administration:** The Veterans Administration supports the following services for qualified individuals:
 - i. Hearing evaluations
Diagnostic evaluations
Aural rehabilitation
 - ii. All services are available to hospital inpatients. All but aural rehabilitation are available on an outpatient basis to veterans who are service-connected for their hearing impairments. War orphans, *i.e.* children of veterans deceased in war or as a result of service-connected disabilities, are eligible for all services offered.
 - iii. Clinical visits for diagnosis are supported. The only restrictions on this function are that the individual must either be seeking admission to the hospital or be authorized by the V.A.R.O., Winston Salem, for such a visit.
 - iv. The V.A.H. supports therapy and retraining programs for the hearing impaired as long as they are inpatients and to a limited extent after they leave the hospital and return on a post-hospital-care basis. At the present time we do not offer these services on an outpatient basis and we cannot hospitalize veterans solely for therapy and retraining, because of a bed shortage on the E.N.T. service.
 - v. The V.A.H. does not support the purchase of hearing aides, but actually furnishes the veteran with hearing aids, a regular and a spare aid. The service is largely restricted to service-connected veterans. The V.A. maintains these aids in functional repair, replaces used cords and tubing, and furnishes batteries, at no expense to the veteran.
 - vi. The V.A.H. supports hospital admissions and surgical connections for hearing impairments for all veterans whose hearing impairments are service-connected. It supports the same services for veterans whose hearing impairments are not service-connected. For the latter, there is an ability-to-pay restriction.
- h) **Medicare:** New medicare coverage now extends to audiological assessments with qualified audiologists.
 Referrals must be for medical and surgical reasons and do not cover the hearing aid evaluation, rehabilitation therapy or purchase of a hearing aid.
 This coverage, however, represents the first breakthrough in assistance to the hard of hearing under a major health program in private, state or federal plans.
 All Medicare clients have a \$50.00 deductible clause on their policy. Coverage is made only after the first \$50.00 of Medicare is paid by the client.
- i) **Commission for the Blind:** The North Carolina Commission for the Blind supports clinic visits for diagnosis and treatment and the purchase of appliances for individuals suffering both hearing and visual handicaps.

2. *Private*

- a) **National Foundation—March of Dimes:** The March of Dimes provides support for patients under 19 years of age with congenital defects (*i.e.*, a structural or metabolic disorder present at birth whether genetically determined or a result of environmental interference during embryonic or fetal life—birth injuries are not included) who have sufficient potential for independent living and provided:

- i. The patient needs treatment, the cost of which would cause an undue hardship to the family.
- ii. The condition is generally accepted by physicians as congenital in origin.
- iii. Disability can be substantially reduced or prevented by treatment.
- iv. The patient is not in an institution for retarded children.
- v. The patient is not eligible for adequate services provided by other agencies.

Appliances can be purchased when prescribed by a physician. Patient aid is handled by local chapters and is dependent on funds available and must be approved by a Medical Advisory Committee.

- b) National Society for Crippled Children and Adults (Easter Seal): Supports medical evaluations, therapy treatments and other rehabilitation services for physically handicapped individuals. Aid is handled by local societies and dependent on funds available.
- c) Service Clubs: A number of private service clubs support individuals with hearing handicaps. Notably among these are: Seratoma Club, Quota Club, Kiwanis Club, and the Lions Club (blind and deaf). These clubs generally give financial assistance on an individual basis.
- d) Foundations: Several foundations, notably the Anne Sullivan Macy Foundation, offer financial assistance in vocational training.

B. *Educational*

A number of Associations, Foundations, and Fraternal Societies offer educational help to deaf and hard-of-hearing individuals. This help is offered in the form of pamphlets, articles, films, and training courses. A list and description of these agencies follows:

ORGANIZATIONS AND AGENCIES FOR THE AURALLY HANDICAPPED

The National Association of the Deaf

In 1880, the National Deaf-Mute Convention, now the National Association of the Deaf (NAD), held its first meeting. In 1890, a constitution was adopted and purposes were stated: "Mutual assistance and encouragement in bettering their standing in society at large, and the enjoyment of social pleasure attendant upon the periodical reunion of a widely scattered class of people." The latest new bylaws of the organization were presented in 1957. The preamble states the aims and purposes of the organization: "The National Association of the Deaf shall be the focal point of the activities of all cooperating state and provincial associations of the deaf in promoting the welfare of the deaf in educational measures, in employment, in legislation, and in any other field pertaining to or affecting the deaf of America in their pursuit of economic security, social equality, and all their just rights and privileges as citizens." It further states that the NAD shall cooperate with its member association of the deaf and give assistance when requested and that the NAD shall be, in fact, a federation of cooperating association of the deaf, and shall also render assistance when possible to individual deaf persons and local groups of deaf persons.

The past few years have been characterized by greatly increased activity. An official publication, *The Silent Worker*, has been published monthly and a national headquarters has been established.

The NAD has striven quite successfully to eliminate unjust liability, compensation, and traffic laws. It has worked to remove barriers against the deaf civil service and in other employment. It stands in favor of the preservation of the language of signs. It has advocated that a strong campaign be under-

taken to educate the public toward a better understanding of "the true place of the language of signs in the lives of the deaf as the means of facile communication for which no practical substitute has yet been devised." It denounces peddling or panhandling by irresponsible deaf persons and believes that there is no necessity for an educated deaf person to beg because of his deafness. The NAD has encouraged homes for aged and infirm deaf, maintained by organizations for the deaf. Homes are located in several states, including California, Georgia, Illinois, Indiana, Massachusetts, New York, Ohio, and Pennsylvania, and in Montreal, Canada.

Further information concerning the publications issued by the NAD and the plans for the future are obtainable from the secretary, Mr. Fredrick C. Schreiber, National Association for the Deaf, 2025 Eye Street, N. W., Suite 311, Washington, D. C. 20006.

The National Fraternal Society of the Deaf

The National Fraternal Society of the Deaf was organized in Flint, Michigan, in 1901 by some young men just out of school who rebelled against the classification of the deaf, by fraternal orders and by insurance companies as "undesirable members or risks." These men combined their needs for adequate insurance with their need for social life to form the nonsectarian National Fraternal Society of the Deaf.

Membership in this fraternal society is open to deaf men and women of all creeds and stations in life; however, not all of them are eligible for membership. Members must be between the ages of 18 and 55 and have "good bodily and mental health." In addition to its sickness, accident, and death benefits, the Society is pledged to give moral, financial, and material aid to its members in time of need. Among other benefits, the Society can provide safe and reliable car insurance for the deaf automobile driver, with public-liability and property-damage coverage. It encourages each member to feel that his interests are the interests of his fellow members. There is a strong feeling of good fellowship, and its members enjoy parties, balls, picnics, lectures, and the like, from time to time. Its meetings are conducted in the language of signs. The *Frat* is its official publication.

The Society operates under the supervision of the Insurance Department of the state of Illinois and is licensed in thirty-eight states and in the Dominion of Canada. Local units are maintained in all the principal cities of the United States and in the provinces of Ontario and Quebec. There are 10,500 members enrolled in the Society, and during its existence, life insurance has been written on the lives of more than 17,000 deaf men and women. Additional information about the National Fraternal Society for the Deaf may be obtained from its home office: 6701 West North Avenue, Oak Park, Illinois. Its grand secretary-treasurer is Mr. F. B. Sullivan.

The Alexander Graham Bell Association for the Deaf, Inc., and the Volta Bureau

The Alexander Graham Bell Association was formed in 1890. Bell, the famous inventor of the telephone, an instrument from which the modern hearing aid is a direct development, was born in Scotland and came by his interest in speech naturally. His grandfather was an authority on speech. His father, Alexander Melville Bell, was acknowledged as the leading phonetician of his day and perfected a simple system of symbols known as "visible speech."

Membership in the association has always been open to anyone interested in having children taught speech and speech reading. Parents of deaf children have found the association a wise counselor and a never failing friend. Through personal correspondence and through literature prepared by experts, thousands of bewildered parents have learned what to do for their deaf children. In 1957 the association provided for an expanded national program, in the interest of deaf children, by organizing a Parents' Section for individuals and establishing a membership classification whereby parent groups have become affiliated with the Association.

Since the Volta Bureau is owned by the Association, its works can rightfully be regarded as a part of the Association's work. The Volta Bureau contains the largest collection of books on the deaf and deafness in America, perhaps the largest in the world.

The first magazine published by the Association was the *Association Review*. In 1910, the name was changed to the *Volta Review*. The *Volta Review* has published thousands of articles dealing with speech reading, the teaching of speech, hearing aids, auditory training, problems of parents of deaf children, and methods of teaching deaf children and hard-of-hearing adults, as well as stories of individuals who have overcome the handicap of impaired hearing, and informative articles dealing with various phases of work with the acoustically handicapped.

Further information about the Alexander Graham Bell Association for the Deaf may be obtained by writing to the Alexander Graham Bell Association for the Deaf, Inc., 1537 35th Street, N. W., Washington 7, D. C. 20007.

The American Hearing Society

The American Hearing Society has as its three major purposes: the prevention of deafness, the conservation of hearing and the rehabilitation of the hard-of-hearing. The program of the Society is "to serve as an information center on problems of defective hearing; to improve the educational, economic, and social conditions among both adults and children whose hearing is impaired; and to stimulate scientific efforts in the prevention of deafness and the conservation of hearing." *Hearing News*, a bimonthly periodical, is the official publication of the American Hearing Society and is sent to all members of the Society. It carries organization news and articles on developments in the treatment of hearing loss, selection of hearing aids, and aural rehabilitation. Speech reading, speech correction, and auditory training are all covered, and advice as to employment and the choice of vocations is featured.

The American Hearing Society also distributes at nominal cost pamphlets dealing with hard-of-hearing children, hearing clinics, tests of hearing, and related subjects. More information about the American Hearing Society may be obtained from Miss Dell Ehrlich, Director, Public Information, American Hearing Society, 919 18th Street, N. W., Washington 6, D. C. 20006.

The American Speech and Hearing Association

The American Speech and Hearing Association is a professional and learned association. It was begun in 1925, and holds annual conventions. The bylaws state: "The purpose of individual human speech and hearing, promote investigation of speech and hearing disorders, and foster improvement of therapeutic procedures with such disorders; to stimulate exchange of information among persons thus engaged, and to disseminate such information." Its official publications are *The Journal of Speech and Hearing Disorders* and *The Journal of Speech and Hearing Research*, which are published quarterly. More information on the organization can be obtained by contacting the executive secretary, Dr. Kenneth O. Johnson, 1001 Connecticut Avenue, N. W., Washington 6, D. C.

The John Tracy Clinic for the Preschool Deaf and Hard-of-Hearing Children and Their Parents

The John Tracy Clinic, located near the campus of the University of Southern California, is a private nonprofit organization devoted to the education of preschool deaf and hard-of-hearing children and their parents. The clinic is housed in a modern building constructed specifically for the education of deaf children and offers training facilities jointly with the School of Education, University of Southern California Teacher Training Program. The goal of the John Tracy Clinic is better educational opportunities and methods for the deaf and the hard-of-hearing. The routine program at the clinic consists of a consulting service which provides a diagnostic interpretation of the preschool child's residual hearing with practical suggestions for education procedures. Classes for parents are open to all parents of deaf and hard-of-hearing children regardless of the age of the child. Classes are made up of: 1) child development and parent attitudes, 2) development of communication skills, and 3) nursery school philosophy and the education of the preschool child. A nursery school is also open to children

2 to 3 years of trained nursery school teachers as well as training teachers of the deaf. Mothers eventually participate in the teaching program. Psychological counseling is always available and has as its purpose the reduction of anxiety, conflict, and pressure; thus freeing parents to handle this problem of deafness in their children. A weekly clinic day is held and provides a situation where the child can be studied further and where the mother may observe his training and avail herself of the opportunity for guidance.

A correspondence course is open to parents of children 5 and under anywhere in the world. The course covers a year's work with a preschool deaf child and is designed to help parents understand the problems of deafness. It includes the first lessons in lipreading, language, sense training, acoustic training and speech preparation. A 6-weeks summer session course for mothers and children living at a distance is offered for additional help. In connection with this session, a course for teachers is offered in conjunction with the University of Southern California. Those parents who are unable to visit or contact the clinic at other times may find the 6-weeks training summer session course very helpful in the plan for their preschool children.

All of the services of the clinic are without charge. Parents may and do contribute to the work as a whole. The program is financed by voluntary contributions. More information on the organization may be obtained by writing The John Tracy Clinic, 806 W. Adams Blvd., Los Angeles, California.

The Convention of American Instructors of the Deaf

The Convention of American Instructors of the Deaf is made up of a membership limited to those engaged in the teaching of the deaf. The convention does not stand committed to any particular method or system of teaching the deaf; its general objective is the "promotion of the education of the deaf on the broadest, most advanced and practical lines. It was initially formed in 1850 and is one of the few educational organizations in the United States that has been in continuous existence and activity for more than a century. Among its valuable contributions have been reports of its meetings held bi-annually which have contained addresses on almost every aspect of deafness. The *Proceedings* of the Convention of American Instructors of the Deaf has been published for many years by the United States Government Printing Office. Its official organ is the *American Annals of the Deaf*.

The Conference of Executive of American Schools for the Deaf

The Conference, formed in 1868, has a membership limited to the administrative heads of schools for the deaf. The object of the Conference is "to promote the management and operation of schools for the deaf along the broadest and most efficient lines and to further promote the general welfare of the deaf." Its most noteworthy contribution is the publication of the *American Annals of the Deaf* which contains its proceedings. The *Annals* edited by Gallaudet College, Washington 2, D. C., is the oldest journal in America dealing with the education of the deaf.

Medical Groups

The American Academy of Ophthalmology and Otolaryngology is the chief American organization of certified otolaryngologists. Through its Committee on the Conservation of Hearing it sponsors public information and research activities about hearing and deafness.

Government Agencies

The Department of Health, Education and Welfare has become active in hearing and deafness in order to carry out the increasing interest of Congress in matters of health and rehabilitation. Through its National Institute on Neurological Diseases and Blindness the National Institute of Health furnishes funds for basic and applied research and for training purposes. The training aims to increase the quality as well as the number of investigators and teachers who are committed to work on problems of deafness.

The Office of Vocational Rehabilitation is interested in promoting and in upgrading the employability of the deaf and hard-of-hearing through grants for research, for rehabilitation, and for the training of professional personnel. Veterans Administration is also active in auditory rehabilitation. Under Veterans Administration policy, outpatient beneficiaries may receive hearing aids and training when the disability is service-connected and when there is a need for them. The Veterans Administration provides direct services to eligible veterans, including auditory assessment and rehabilitation, and it carries on research, training, and consultation of considerable scope.

Other organizations whose activities touch on problems of hearing and deafness are the following: The Acoustical Society of America, The American Federation for Physically Handicapped, The American Public Health Association, The Council for Exceptional Children, The National Rehabilitation Association, and The National Society for Crippled Children and Adults.

The list of organized groups and agencies is formidable and impressive, and it suggests that we may be encouraged by the outlook for the deaf and hard-of-hearing in the years ahead.

The information given above has been taken from the book *Hearing and Deafness* edited by Hallowell Davis, M. D., and Co-edited by S. Richard Silverman, Ph.D., revised edition, 1961, Chapter 23. This book is published by Holt, Rinehart and Winston, Inc., New York.

International Parent's Organization

Parent's Section

Alexander Graham Bell Association for the Deaf, Inc.

1537 35th Street, N. W.

Washington, D. C. 20007

A. HISTORY OF THE PARENT'S SECTION

The National Parent's Organization was formed in the year 1957. The formation of this group was resultant of a resolution presented to the Alexander Graham Bell Association by the Massachusetts Parent's Association for the Deaf and Hard-of-Hearing. The Massachusetts group had proposed the organization in 1956. Action of the Alexander Graham Bell Association's Board of Directors created the SECTION in 1957, and at the biennial summer meeting in Pittsburg in 1958, organization was completed and the first officers and Governing Board were selected by parents attending that meeting. Due to the efforts of this group, the action taken made possible the unity of parents of deaf children everywhere.

Although the PARENT'S SECTION is relatively new, the Alexander Graham Bell Association itself has a long history. It was established in 1890 by the outstanding scientist and teacher of the deaf whose name it now bears. The Association is internationally known as an information center on deafness and as a vigorous advocate of oral education for the deaf.

B. WHAT DOES THE SECTION DO?

The PARENT'S SECTION and the Association have common activities which carry out the following purposes:

1. To promote the teaching of speech and lipreading to deaf children.
2. To strive for a better public understanding of the problems of deafness and communication disorders.
3. To advocate an expanded research program in matters pertaining to deafness.
4. To assist schools and other agencies in working for better educational facilities for all deaf children.
5. To encourage capable people to become teachers of deaf and language-handicapped children.
6. To gather and disseminate knowledge concerning deafness.
7. To share information with all people interested in deafness in an effort to understand common problems.

C. HOW IS THE SECTION ORGANIZED?

The PARENT'S SECTION is organized within the framework of the Association. Acting in an advisory capacity is a standing committee of the Board of Directors of the Association.

The activities of the PARENT'S SECTION are directed by a Governing Board. The Board is elected by the parents at each biennial meeting of the Section and is responsible to the Parent's Committee. Officers of the PARENT'S SECTION are elected by the parents at each biennial meeting and are responsible to the Governing Body.

D. WHO MAY JOIN?

Any organized group of parents of deaf children may be admitted as an affiliate of the PARENT'S SECTION. Groups of parents whose children have been diagnosed as aphasic, brain-damaged, language-impaired or multiple handicapped with a primary communication problem have also asked for and been granted admission to the PARENT'S SECTION. Most of these children are being educated in special classes in schools for the deaf and their parents share many of the problems of parents of deaf children.

Membership within a group is counted in member-families; i.e., both parents constitute one member. Membership is not limited to parents, but may include other family members or interested persons. An individual may, if he wishes, join the PARENT'S SECTION by paying the usual Association dues (\$5.00 per annum plus 50 cents for foreign postage where pertinent) and designating himself a member of the PARENT'S SECTION. Membership entitles him to voting privileges in the Section and in the Association itself and to a copy of each issue of the *Volta Review*.

E. WHY JOIN THE PARENT'S SECTION?

The SECTION enables parents of deaf children, for the first time, to speak with unified strength, as parents of other handicapped youngsters have been doing for years. This cannot help but assist in improving schools, in making the public increasingly aware of the problems of the deaf and in affecting legislation on all levels.

Joining gives parents an opportunity to participate in the formation and execution of broad scale programs devoted to better education for all deaf children, to a better understanding of their problems and to their satisfactory adjustment in a hearing world.

F. WHAT BENEFITS DOES MEMBERSHIP BRING?

1. A copy of the monthly *Volta Review* for each 20 members. Each month a special parents' section tells what affiliates are doing. There are special articles by and for parents.
2. A copy of the monthly newsletter for each member family. The newsletter keeps you up-to-date on news of interest to parent groups, gives program suggestions, allows you to communicate with other groups.
3. Services of the national Speakers' Bureau, which now involves more than 100 speakers.
4. Films and tape recordings to borrow free of charge.
5. Free literature on request to aid in recruiting teachers and informing the public about deafness.
6. The privilege of borrowing books from the Association's lending library.
7. Assistance with your group's special problem through correspondence with the Association staff or by referral to local sources of help.

G. HOW TO JOIN

1. By resolution, your group must accept the purposes and objectives of the Alexander Graham Bell Association for the Deaf as contained in Article II of the Constitution. (See below.)

2. Annual dues of \$1 per member-family must accompany your request for affiliation. (Groups of 20 or fewer members pay a minimum annual fee of \$20.) Groups may join at any time during the year, with membership extending to one year from date of joining.
3. An annual list of members and their addresses must be submitted.

ASSOCIATION OBJECTIVES

The objectives of the Alexander Graham Bell Association for Deaf, unchanged since they were originally written by Dr. Bell and included in Article II of the Association's Constitution, are:

1. To aid schools for the deaf in their efforts to teach speech and speechreading by encouraging schools for the training of articulation teachers, by the employment of an agent, who shall, by the collection and publication of statistics and papers relating to the subject, and by conference with teachers and others, disseminate information concerning methods of teaching speech and speechreading, and by using all such other means as may be deemed expedient to the end that no deaf child in America shall be allowed to grow up "deaf and dumb" or "mute" without earnest and persistent efforts having been made to teach him to speak and to read the lips; thus carrying out that portion of the resolution unanimously passed by the eleventh Quadrennial Convention of Instructors of the Deaf, held at the California Institute for the Deaf and Dumb, at Berkely, California, July 15-22, 1886, which reads as follows: "Resolved, That earnest and persistent endeavors should be made in every school for the deaf to teach every pupil to speak and read from the lips."
2. To gather information respecting the instruction in speech given in schools for the deaf.
3. To obtain from schools for the deaf statements of the difficulties encountered in teaching speech to their pupils, to the end that this Association may offer such aids as may be in its power to overcome these obstacles.
4. To arrange for special courses of lectures and discussions upon subjects relating to the teaching of speech and speechreading and the use of speech by the deaf.
5. To publish from time to time such papers or articles as may in the judgment of the Board of Directors be worthy of special presentation to teachers of the deaf and those interested in oral instruction.
6. To cooperate with the conventions of the instructors of the Deaf.

II. Analysis and Recommendations

A. *Analysis*

1. Figure 10 shows a breakdown of financial assistance available from different agencies and the ages served by these agencies. It can be noted that all agencies surveyed support evaluations and treatment. This evaluation takes the form of diagnosis of the hearing impairment. Treatment may be in the form of medical and/or dental treatment and therapy (such as: speech therapy, auditory training, speech reading, physical therapy, etc.). Some agencies support corrective surgery in addition to evaluation and treatment. Also, some agencies support the purchase of appliances (i.e., hearing aids) as well as evaluation and treatment. In addition, some agencies support a full range of services.
2. Further analysis of Figure 10 shows that there are many special agencies, established for the purpose of serving particular groups. Notably among these are: Head Start (nursery school and kindergartens), ESEA and School Health Fund (school age), Medicare (over 65 years), Vocational Rehabilitation (15-65 years), Crippled Children's Section (birth to 21 years), and Commission for the Blind (serving those with both visual and auditory handicaps). Only the Public Welfare Department spans the entire age range for non-special interest groups.

3. It would seem, from these data, that the most complete service is offered by Crippled Children's Section of the State Board of Health and Vocational Rehabilitation. In addition, it is evident that there is considerable overlapping and duplication of service among the different agencies.

B. *Recommendations*

1. It would seem apparent that the elimination of overlap and duplication of services among the various agencies would be of benefit. This, of course, should be coupled with a strengthening of the agencies that cover these services. The logical agencies to cover the majority of the population would seem to be the Crippled Children's Section and Vocational Rehabilitation, since they already have the mechanism to provide these services. These two agencies, with additional funding and slight changes in eligibility requirements, coupled with Medicare, could effectively serve the population. Medicare coverage, however, would have to be expanded to cover the purchase of appliances.
2. Types of coverage would seem to break into a convenient dichotomy: medical and/or therapeutic and educational. It might be recommended, therefore, that several of the agencies might be restructured (i.e., School Health Fund, Crippled Children, Vocational Rehabilitation, Public Welfare, and Medicare) and adequately funded to serve the medical and/or therapeutic needs of deaf and hard-of-hearing individuals. The other organizations (i.e., Head Start, ESEA, and Department of Public Instruction) should be concerned with the educational needs of these individuals. The agencies serving specialized populations (i.e., Veterans Administration and Blind Commission) would, by necessity, be excluded from this program and would continue to serve their populations.
3. It is further recommended that a state level commission, similar to the Commission for the Blind, be established to serve as a liaison between needy individuals and various agencies. In addition, this Commission might serve in the capacity of organizing and recommending additional services.

Respectfully submitted,

Sub-Committee on Agency Support
William G. Thomas, Ph.D., Chairman
Ralph Stegall
Neal Peyton

REPORT OF TASK FORCE ON HEART, CANCER AND STROKE

The Governor's Study Committee on Vocational Rehabilitation respectfully submits the following recommendation:

The State of North Carolina should immediately begin the development of one or more comprehensive vocational rehabilitation and training centers. The need for such facilities is described in Appendix I.

The Comprehensive Vocational Rehabilitation Center (centers) should include medical and paramedical services needed to restore, improve and/or maintain the physical capacities of seriously disabled people whose chronic condition, if left unattended or inadequately attended, may result in either total disability or an unduly severe handicap.

Other components of a comprehensive rehabilitation center would include adequate psychological services for evaluating functional capacities and helping the seriously disabled individual attain a degree of adjustment to his condition so that the individual might capitalize on his remaining assets and be able to fully utilize the many resources made available to him by State, local and private resources. A social work program that is sufficiently strong to help the patient and his family adjust to the complications caused by disability is also needed. For such a center to be of maximum value, there should be a sufficiently large number of vocational training programs available so that the disabled individual can train in an area of employment suitable to his disability, capabilities and interest. It is felt that without an opportunity to engage in a proper and stimulating vocational training program concurrently with medical, psychological and social attention, the entire impact of a rehabilitation center would be seriously jeopardized. Further explanation of this point may be found in Appendix II.

The purposes of a comprehensive rehabilitation center (centers) would be three fold:

- (1) To provide for the service needs of seriously handicapped people who must now be sent out of state for such services.
- (2) To provide a clinical laboratory for training rehabilitation personnel who are presently in very short supply in relation to the need which exists in our State. Such personnel would include physicians, nurses, physical therapists, occupational therapists, social workers and rehabilitation counselors.
- (3) Such a center should also provide rehabilitation personnel with an opportunity to do continuing research on all aspects of rehabilitation problems; thereby, strengthening and making our rehabilitation efforts at the community level far more economical and efficient.

In order to achieve the kind of program which is desirable, it is felt that the State's Division of Vocational Rehabilitation, Department of Community Colleges and Technical Institutes and the University of North Carolina should do joint planning. Each of these agencies and facilities should be encouraged to give high priority to this project. Such a project possesses the potential for providing answers to some of our State's most acute problems, i.e. services to severely handicapped people, training of needed manpower, and research regarding rehabilitation.

The State should place highest priority on involving the University of North Carolina at Chapel Hill in such rehabilitation facility planning and programming since the University and its medical school already encompasses highly competent, interested professionals who have already visualized the multiple benefits which would accrue from the establishment of such a center. The University has also, in the recent past, sponsored a rehabilitation planning program conducted by Dr. Harvey L.

Smith, Ph.D., Social Research Section, Division of Health Affairs, University of North Carolina, which describes the involvement of many of the University's major departments in a rehabilitation complex and the functional value which the university could accrue. It would seem mandatory to have the official involvement of the outside agencies previously mentioned to insure that the University sponsored rehabilitation center places at least an equal amount of emphasis on meeting service needs as it would naturally place on its training responsibilities. It is not necessarily being recommended that the functions of all of these agencies should be housed under one roof; but it is highly desirable that they be housed in a complex, facilitating easy movement of a patient-client in and out of each service area.

As mentioned earlier, it is probably desirable for long range planning purposes to recognize that one center cannot adequately serve the needs of the State. In order to achieve the same service goals and at the same time utilize existing resources and conserve manpower in addition to creating an enlarged manpower pool, similar arrangements should be explored with other university affiliated major medical centers across the State. It would seem highly desirable to explore the potential present in a combination of the resources of North Carolina Baptist Hospital in Winston-Salem, the North Carolina Division of Vocational Rehabilitation, the Department of Community Colleges, Whitaker Convalescence Hospital, Goodwill Industries Sheltered Workshop and Training Center, and Wake Forest University.

Other rehabilitation center possibilities which might be available for development are located within the Asheville area. Information has been brought to this committee's attention which indicates interest on the part of Asheville Orthopedic Hospital in Developing a comprehensive rehabilitation center to provide services to vocational rehabilitation clients. There is also a possibility that the recently vacated Veterans Administration Hospital facilities at Oteen will become surplus federal property and available to the State if a proper application were made. A thorough investigation of the feasibility of developing a center in this area, either at the Asheville Orthopedic Hospital or the Oteen facility or a combination of both, should be encouraged and given State legislative support.

Summary

1. The population of North Carolina, which reports having some degree of limiting disability, constitutes a large number of people. A pressing need of many of these individuals is for a comprehensive rehabilitation center whose resources can bring to bear multiple services simultaneously for solving their very complicated problems.
2. The University of North Carolina at Chapel Hill should be urged to give highest priority to the development of a comprehensive rehabilitation center to be built in connection with or adjacent to North Carolina Memorial Hospital. The University should further be urged to involve the State Division of Vocational Rehabilitation and the Department of Community Colleges in their planning for a well rounded program.
3. The State should make money available immediately for the technical planning of the rehabilitation center facility. Since sources at the University have contemplated a facility of 120 in-patient beds and since the Medical Care Commission uses as a rule of thumb \$25,000 construction cost for each patient bed and since architectural fees for planning such a facility equals 6 per cent of the construction cost, it would appear that at least \$180,000 should be made available in this biennium. Additional money in an amount appropriate for planning the trade training component of the rehabilitation center should be made available to the Department of Community Colleges.
4. Appropriate agencies or governmental bodies should be called on to immediately begin exploring the possibilities for developing other comprehensive rehabilitation centers where existing resources present a potential for such development. Possible sites would be in Winston-Salem, in connection with Bowman Gray School of Medicine; Asheville Orthopedic Hospital in Asheville; and at an appropriate center in the eastern part of the State.

In 1965, the Vocational Rehabilitation Administration conducted a study to determine the number of disabled people in the United States that could benefit from State Vocational Rehabilitation Agency services and are legally eligible and feasible for vocational rehabilitation services. At the time that this estimate was made, it was recognized that the procedure used would necessarily result in a very conservative estimate. However, using even this conservative figure, North Carolina should legitimately have at least 89,658 (based on 1967 population estimates) disabled people in its population who would need and be eligible for vocational rehabilitation services.

Based on a recent study sponsored by the North Carolina Study in Vocational Rehabilitation and conducted by the Department of Sociology and Anthropology at North Carolina State University, it was discovered that approximately 22 per cent of the surveyed population described themselves as either partially or totally disabled. This figure seems high but can partially be explained by the fact that about 60 per cent of the disabilities reported came from persons over fifty years of age. This high prevalence of disability is also in line with the findings of a nationally recognized study "The Handicapped Children of Alamance County, North Carolina" conducted by William P. Richardson, M.P.H., Professor of Preventive Medicine and Assistant Dean of Medicine, University of North Carolina in 1965.¹ In this study it was found by clinical examination that "43 per cent of the group had some recordable condition" and 20 per cent with moderate or severely handicapping conditions. Using the available North Carolina estimates, it would appear that there are 1,101,053 persons who are, or feel that they are, limited in some way by physical, mental, or emotional factors. Unfortunately, there is very little information available concerning the degrees of handicap in our population. We do have State projections based on national estimates for a few conditions. Other information is being gathered at this time. In this state there are approximately:

4,000 paraplegics
 1400-2800 stroke victims who suffer residual effects per annum
 100+ new cerebral palsy victims per annum
 Over 300,000 heart conditions²

According to estimates based on findings of a three county survey in North Carolina, there is approximately 22.5% of the population that report some form of disability. These are broken down as follows:

Visual Impairment	7.2%	79,245
Hearing	2.8%	30,829
Orthopedic Deformities or Functional Impairment	42 %	462,442
Amputations	2.4%	26,425
Mental, Psychoneurotic	6.9%	75,972
Allergies, Endocrine Disorders, Metabolic Nutritional	4.8%	52,850
Cardiac and Circulatory	18 %	198,189
Diseases of Blood	.8%	8,808
Respiratory	2.8%	30,829
Digestive	3.6%	39,637
Genito-Urinary	2.4%	26,425
Not Elsewhere Classified	3.2%	35,233
2 Major Disabilities	.4%	4,404
3 Major Disabilities	1.6%	17,616
4 or More Major Disabilities	1.6%	17,616

Total estimated disabled population in North Carolina, 1967 1,101,053³

It should be noted that the prevalence of mental and psychoneurotic disorders is far below nationally accepted estimates for our State's population. This may be explained by the fact

¹William P. Richardson and A. C. Higgins. *The Handicapped Children of Alamance County North Carolina*. Nemours Foundation, Wilmington, Delaware, c. 1965.

²Rehabilitation Symposium on Cardio-Vascular Diseases, National Science Foundation, New York, 1967.

³Vaughn, L. Grisham, *A Report of a Survey in Durham, Pitt, and Transylvania Counties Concerning Disabilities*, N. C. Study in Vocational Rehabilitation, Volume I.

that individuals hesitate to discuss the presence of these conditions within their household with a survey interviewer.

Other more subjective data which should be considered is that the Vocational Rehabilitation Agency in 1967 would not accept for services 711 referrals because they were too severely handicapped to be rehabilitated with available resources.

Ten vocational rehabilitation counselors sent 19 handicapped people to Woodrow Wilson Rehabilitation Center in Fishersville, Virginia last year. These counselors were subsequently questioned regarding the numbers of people they see in a year's time who could only be served by a comprehensive rehabilitation facility and the questioning resulted in each counselor reporting seeing four to five clients a year. If all general rehabilitation counselors encountered at the same rate persons needing comprehensive rehabilitation services, there would be an estimated 300-375 persons per year needing these services. There are obviously many more who would make themselves known to the Agency if facilities were available.

Information from Woodrow Wilson Rehabilitation Center in Fishersville, Virginia indicates that the cost of rehabilitation services for out-of-state clients is approximately 40 per cent more than the cost to citizens of Virginia.

Woodrow Wilson Rehabilitation Center in Virginia at one time attracted clients from Pennsylvania, West Virginia, Maryland, North Carolina, and South Carolina. The Center no longer serves clients from Pennsylvania or West Virginia who have developed centers of their own, and it gets a reduced number of clients from Maryland because many of their clients are located closer to the Pennsylvania center. In spite of getting fewer clients from out-of-state, Virginia is opening an additional center at Norfolk because it is known that both centers will be fully utilized and that, in fact, there will be need for two or three other centers.

South Carolina and Maryland have both recently had a planning grant to study their state's needs for a comprehensive multi-disciplinary vocational rehabilitation center. The need was unequivocally established and plans are being made to build facilities in those states. There is no reason to believe that North Carolina's needs are any less.

Besides the expense of using out-of-state facilities, the counselors of the North Carolina Vocational Rehabilitation Agency have indicated that there are other more pungent problems; the first being that many severely disabled clients find it terribly difficult to leave their home state and their families for rehabilitation center services. Secondly, there is a long waiting period involved in an out-of-state client being admitted to a facility oriented toward providing services for its own citizens. Next, there is considerable disadvantage in separating the client from his home counselor and from home resources that will ultimately have to provide the client with employment.

A seriously handicapped individual who needs comprehensive vocational rehabilitation center services has a multiplicity of needs which could undoubtedly be served by resources presently available within the State. However, in many instances the client's needs are so intertwined that none of them can be met unless the other needs are receiving attention simultaneously. For example, the attached chart is a simple diagram of needs that may be faced by a person who has just suffered a severe traumatic injury or illness which may result in chronic impairment. The patient's first primary need is for acute medical attention. The main focus, at this time, is preserving life. However, as acute wounds or illness subsides, the patient's need for medical care decreases and continues its decline until a very minimal level of medical care is needed. This minimal medical care may, in fact, always be at just a slightly higher level than medical care required by non-injured or non-disabled individuals.

As the need for acute medical care decreases, the need for physical care increases. These needs may be for physical therapy, occupational therapy, rehabilitation nursing, and adjustment counseling. All of these activities are directed at minimizing the disability which may, and often does, persist after even the best of acute medical care. As physical needs are met and maximum functional return is gained and after the individual has made enough social and psychological adjustment to be able to maintain the gain that has come through treatment, vocational needs become paramount.

If a person is to have a fruitful, happy life after becoming disabled, he must be helped to reach his fullest productive capacity. This may entail initial job training for the young person who has never gained a work skill or it may involve the retraining of the individual for a new occupation or special adaptations for return to an already established occupation.

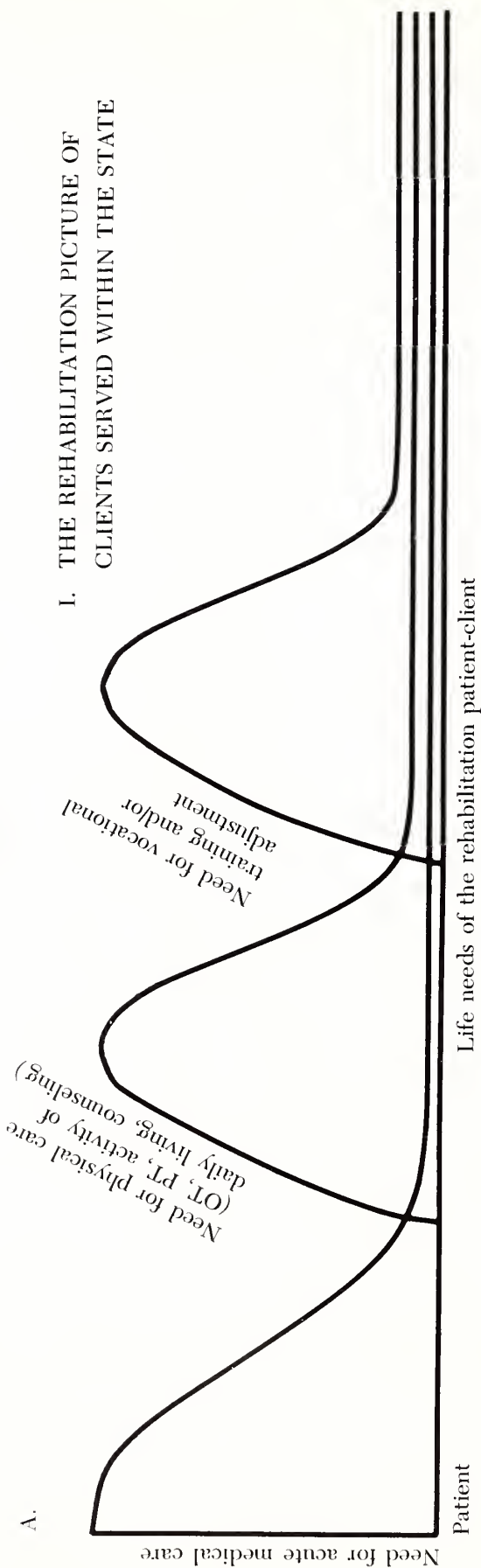
Figure 12A in the chart illustrates the way that we, in this State, generally have to deal with a severely handicapped person. Acute medical needs physical care and vocational training or adjustment is provided in separate and distinct facilities that have very little or no communication with each other. Generally, needs for medical care have to be met before physical, emotional components are handled and so, too, are vocational adjustment services separated. Figure 12B depicts the services received by severely disabled people who are lucky enough to be sent out-of-state to a comprehensive rehabilitation center. Their medical needs have to be almost totally completed before they are considered for an out-of-state rehabilitation center and then there is a long delay between the time medical needs are met and an out-of-state center can be entered. Once the out-of-state center admits the patient client, however, there is a suitable overlap between meeting physical needs and vocational or occupational adjustment needs. However, the long delay between acute medical care and the institution of physical care may result in unnecessary complications arising so that the individual has to be sent back to the hospital for additional medical care before physical care can be utilized maximumly. Figure 12C illustrates the ideal rehabilitation process for a severely handicapped individual and this pattern of service can only be assured North Carolina residents if comprehensive rehabilitation facilities are developed. In this illustration, we see that there is considerable overlapping between provision of medical care, physical care and vocational or occupational care. As soon as the acutely ill patient begins to need less life-saving care, his needs for physical care begin to diminish, vocational or occupational care should begin. This overlapping of services greatly reduces the time involved in the rehabilitation process.

In addition to saving time, by overlapping services, we are meeting the needs of the individual at the time they occur and, thereby, are much more likely to have a motivated client who will make maximum medical, physical and vocational adjustments. For example, the acutely injured person cannot derive maximum benefit from medical care unless he sees in himself developing physical capacities for having a "good life". Also, maximum benefit from physical care and maintenance of physical abilities is not motivating unless the individual sees within himself some capacity for meaningful production. Thus, it must be said that the meeting of each need provides motivation to claim maximum benefit from each service.

(See pages 293 and 294.)

Figure 12

I. THE REHABILITATION PICTURE OF CLIENTS SERVED WITHIN THE STATE



B. The rehabilitation picture of clients sent out of state

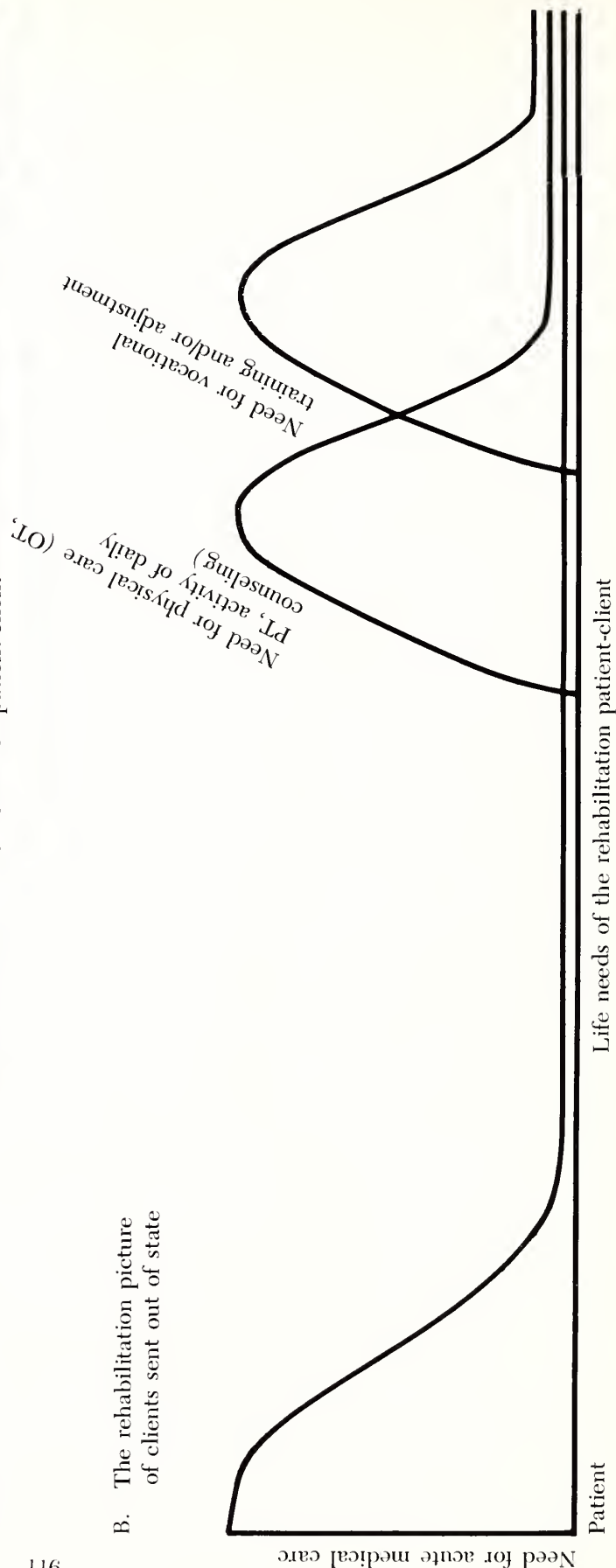
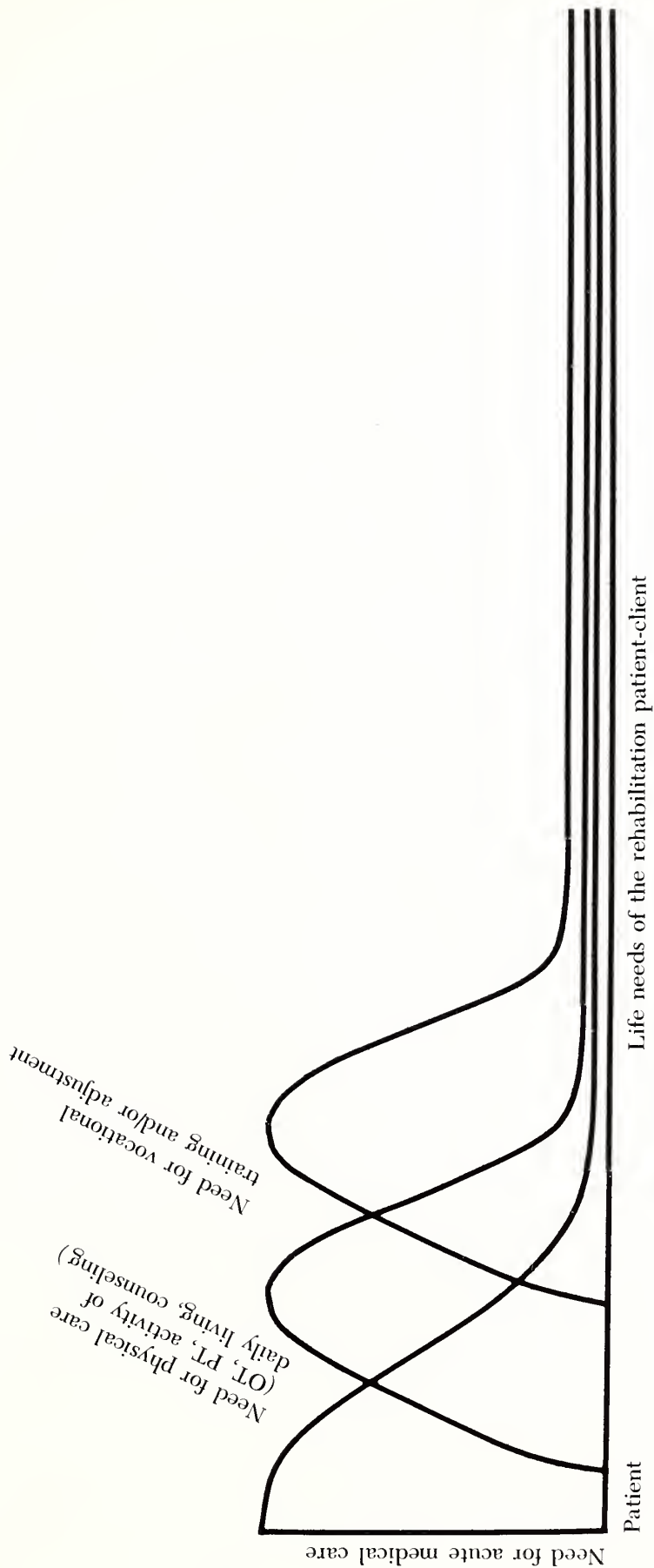


Figure 12 Cont.

C. The ideal rehabilitation process



REPORT OF THE TASK FORCE ON MENTAL HEALTH

NEEDS

1.
 - a. People who have received treatment for mental illness need special psychological support as they go out on their new jobs. It is of prime importance that the vocational rehabilitation counselor give this support and not put the client on the job to be forgotten.
 - b. IT IS RECOMMENDED that these clients need closer supervision on the job; that is to say that the employer at least for an interim period should be willing to offer extra support in the special crisis period of the first few weeks.
 - c. It is thought that vocational rehabilitation, the Department of Mental Health and the State Association of Mental Health could work together in a widespread public relations or public information program which would help the community and employers to understand the problem and, thus, make rehabilitation for the mentally ill a reality instead of a dream.

PROBLEMS

1. There is a need for vocational rehabilitation, on the state level, to set up a clear, concise policy regarding rehabilitation of the mentally ill. There are indications that state agency policy, might at the present, find itself *altered* in the various district offices. In other words, some district offices might tend to skirt the category of the mentally ill and not give proper service to this category.
2. The “*closure*” *system* needs much review. It is a foregone conclusion that working with the mentally ill might be a long and tedious process and any counselor who is worried or preoccupied with the clock or completion of the case will be of little aid to the prospective client. Also, credit for this closure is unimportant because many agencies may be working with vocational rehabilitation on a particular case and, after all, a successfully rehabilitated client is the ultimate goal. It makes little difference who gets credit for this success.
3. There have been technical problems between the Division of Vocational Rehabilitation and the Department of Mental Health because their districts aren’t congruent. The elimination of this problem is near, however, because Vocational Rehabilitation and Mental Health have drawn up a plan whereby the districts will be the same for each and there will be no overlapping. In other words, a county which works with a vocational rehabilitation office will work with a mental health office from the same area. It is hoped that this plan will be effective in a few months. Of course, as we move to the concept of comprehensive mental health centers, we must have top coordination and cooperation in order to achieve success.
4. Vocational Rehabilitation should familiarize itself more with other available services and when it finds itself unable to render services, it should be able to *refer the client* to the proper agency and not leave him “up in the air”.

PERSONNEL

1. There is a marked lack of personnel now available to work with the mentally ill. IT IS RECOMMENDED that immediate steps be taken to assure that proper numbers will be hired to overcome this deficiency.

2. It is of utmost importance that those working with the mentally ill have special training. A "general" counselor could not hope to successfully relate to the special problems of this categorical group. There has been discussion as to what type of training would be best and it is generally agreed that some type of *pre-service training* is necessary and that in-service training after employment be conducted by *well qualified specialists* or consultants. It may well be that, after a period of time, Vocational Rehabilitation could have counseling specialists who could assist with this training.

SUGGESTIONS

1. MORE WORKSHOP PROGRAMS should be devoted to the needs of the mentally ill. It is clear that the workshop programs in North Carolina at present are clearly oriented to the needs of the mentally retarded and, for the most part, are controlled by the Association for Retarded Children. This very worthy program shouldn't be curtailed but an effort toward a more comprehensive program would greatly aid the chances of the mentally ill to receive services. If this change can't be achieved, it might be necessary to look in the direction of separate workshops for the mentally ill.
2. IT IS HOPED THAT VOCATIONAL REHABILITATION WILL ASSIGN COUNSELORS TO THE COMPREHENSIVE MENTAL HEALTH CENTERS AS THEY DEVELOP. Early placement in these centers would greatly aid the planning for future services.
3. IT IS SUGGESTED THAT LOCAL ADVISORY COMMITTEES ON REHABILITATION AND EMPLOYMENT OF ALL HANDICAPS BE DEVELOPED. These committees could go a long way in implementing the public information program discussed earlier.
4. IT WOULD BE HELPFUL TO HAVE A COORDINATOR TO WORK AMONG AGENCIES SUCH AS MENTAL HEALTH, MENTAL INSTITUTIONS, COMPREHENSIVE CENTERS, WORKSHOPS, HALFWAY HOUSES, ETC. This person could coordinate services and training with these agencies and the teaching institutions and the end result could be a better understanding of all personnel to other services and programs offered.
5. IT IS THOUGHT THAT INVOLVEMENT ON LOCAL AND STATE LEVELS OF VOLUNTEER ORGANIZATIONS COULD GREATLY SUPPLEMENT THE SERVICES OFFERED BY AGENCY PERSONNEL. These volunteers could work as aides possibly and help offset the inadequate staffs that now exist. It is clearly recognized that state and local agencies haven't even scratched the surface in the use of volunteers.
6. THE STATE OF NORTH CAROLINA MUST DECIDE THAT REHABILITATION IS AT LEAST IMPORTANT ENOUGH TO UTILIZE TO THE FULLEST EXTENT THE FEDERAL DOLLARS THAT ARE AVAILABLE TO ASSIST OUR STATE PROGRAMS. Each year we have failed to match our share and have seen our dollars go to another state which did. Rehabilitation pays for all disability groups and it is the state's responsibility to do its fair share.

RECOMMENDATIONS OF THE TASK FORCE ON MENTAL RETARDATION

- I. Recommend that Vocational Rehabilitation Programs and Education Programs study methods to encourage integration of Special Education Programs with any and all Vocational Training Programs; so that the mentally retarded child is prepared in Special Education to enter vocational training at the earliest time possible.
- II. Recommend that the North Carolina Division of Vocational Rehabilitation consult with the Governor's Council on Mental Retardation in planning programs for the mentally retarded. This council has the legislative mandate for total planning in Mental Retardation Services.
- III. Recommend, whenever feasible, that the workshop work cooperatively with the Community College, Technical School, Industrial Education Center, and/or institute of higher learning within the immediate area in utilizing each other as a resource for services to workshop clients and for training specialized professionals.
- IV. We recommend that there be developed three (3) full-time positions which would be filled by experienced Vocational Rehabilitation, Mental Retardation specialists.
 1. The first position would be to assist with planning, coordination, and development of special education programs.
 2. The second position would be to assist in establishing within the Department of Community Colleges training programs for personnel who will work in community services for the retarded.
 3. The third position would be that of Assistant Director of Mental Retardation Services with delegated responsibility for directing all mental retardation services for the North Carolina Division of Vocational Rehabilitation. This position would have available funds to utilize out-side consultants.

The above recommendations are supported by Dr. Robert I. Jaslows' pamphlet entitled, "A Modern Plan for Modern Services to the Mentally Retarded," published by the United States Department of Health, Education, and Welfare, Social and Rehabilitation Services Administration.

- V. We recommend a program of career incentives to be established to encourage maximum development within a position (Career Counselors) without necessarily requiring a change in position in order to earn salaries associated with supervisor level positions.
- VI. We recommend that there be a review of the salary scales to consider a differential beginning salary for those who enter the Vocational Rehabilitation profession with a Masters Degree in Rehabilitation Counseling, or in a related field.
- VII. In order to meet the rehabilitation goals that this State and other states have set for themselves, it will be necessary to greatly increase the emphasis on in-service training—since the existent university programs cannot even begin to meet the Rehabilitation Counselor manpower need. The North Carolina Division of Vocational Rehabilitation Agency should support in-service training in facilities which provide services to the vocationally handicapped, such as the workshop program.

- VIII. The Mental Retardation Task Force strongly recommends that one and one half million dollars in additional funds be sought to allow present workshops to operate at their maximum capacity and to allow for modest expansion of additional workshops. The above funds are to be used for case service money for the fiscal year beginning July 1, 1968.
- IX. Recommend that the Department of Mental Health seek additional funds for the fiscal year beginning July 1, 1968, to allow the grant-in-aid program for the sheltered workshops to operate at the capacity level for the type of client usually served by the Grant.
- X. Recommend to the North Carolina Division of Vocational Rehabilitation that they request the the Department of Mental Health to assume full financial responsibility for the "terminal" clients in the workshop, and seek an increase in monthly support from \$40 to \$60 per month for the biennium beginning July 1, 1969, and that the Department of Mental Health assume the certification of the clients in each workshop and assist in developing adequate programs both in the workshop and community.
- XI. We recommend that the North Carolina Division of Vocational Rehabilitation provide or arrange for other appropriate agencies to provide rehabilitation homes for the workshop clients who do not find it feasible to commute and are in need of residence facilities while in training at the workshop.
- XII. Recommend the North Carolina Division of Vocational Rehabilitation consider establishing and supporting permanent residence facilities, or seeking support through other appropriate agencies (such as the Department of Mental Health) for permanent residence facilities where a home-type atmosphere is provided for clients who have completed their work training and are currently employed in community surroundings, or in the workshop.
- XIII. Recommend that the North Carolina Division of Vocational Rehabilitation consider "Extension Training Programs" for clients confined to their homes; those who do not find it feasible to commute to a workshop daily.

The Task Force on Mental Retardation will continue to serve in an advisory capacity to the Governor's Committee.

PUBLIC OFFENDER TASK FORCE

The Public Offender Task Force was unique from the beginning in that most of its members were employees of the State of North Carolina or of the courts of North Carolina; there being no special social agencies in the state dealing with the problems of the Public Offender. It should be pointed out that the Task Force is including in its definition of *Public Offenders*, those who have been placed on probation by the courts but have never been incarcerated.

This report will mention some of the questions raised but not necessarily answered and also some of the group's definite recommendation. Much discussion centered around the common family and social problems that seem to cause a person to become an offender; most of the probation officers in the group agreed that a case study of one public offender was much the same as another because of similar backgrounds but it was pointed out by others present that many probationers were traffic offenders, for instance, and had not had the history of deprivation prevalent in many prisoners or parolees.

Public information was a subject discussed thoroughly. It was thought by the group that each department dealing with the offender would have to step up its program of public information, not only for the benefit of the program itself, but also for the recruitment of professional personnel. North Carolina has no degree program in Penology; it was thought, however, that schools which offered Criminology in their Sociology curriculums should aid by incorporating more information about North Carolina's specific problems and its future plans for the field of Corrections.

A good part of one of the task force meetings was spent in explaining our state's new co-operative program between Vocational Rehabilitation and the Board of Juvenile Correction, the reason for this being that most members of the Task Force were not aware of the program since they were, in the main, representatives of adult disciplines. Many of the services offered by this co-op. program were discussed as being applicable to the adult prison community.

As pointed out in an earlier report, the task force was adamant in its proposal THAT DEFINITE GOALS ARE A PROGRAM NECESSITY. ALSO NEEDED ARE PARALLEL PROGRAMS IN A WELL PLANNED FOLLOW-UP SYSTEM. Many members felt that the most ideal "inside the wall" program would fail without proper preparation by and for the offender on the outside. PART OF THIS SHOULD COME FROM AN EDUCATIONAL PROGRAM IN THE COMMUNITY. THE COMMUNITY MUST REALIZE THAT THERE ARE PROBLEMS AND SINCE THE RELEASED OFFENDER IS A COMMUNITY CITIZEN, HE MUST BE GIVEN A PLACE; TO SHUT HIM OFF COMPOUNDS NOT ONLY HIS PROBLEMS BUT THE COMMUNITY'S AS WELL. EDUCATION, ESPECIALLY FOR THE YOUNG, SHOULD BECOME OF PRIME IMPORTANCE BECAUSE TRADITIONAL EDUCATION SYSTEMS IN MANY CASES HAVE BEEN AN OBSTACLE AND MAY HAVE BEEN ONE OF THE FIRST CONTRIBUTING FACTORS TO AN OFFENDER'S BRUSH WITH THE LAW.

MUCH DISCUSSION CONCERNED THE ESTABLISHMENT OF HALFWAY HOUSES FOR RELEASED OFFENDERS SO THAT THEIR TRANSITION PERIOD MIGHT BE ACHIEVED MORE EASILY. IT WAS FEARED THAT AN OFFENDER MIGHT FALL BACK INTO THE SAME TROUBLE IF HE WENT BACK IMMEDIATELY TO HIS HOME SITUATION, WHICH WAS PROBABLY A VERY BIG CONTRIBUTING FACTOR IN HIS DEVELOPMENT AS AN OFFENDER. It should be pointed out that there were those who thought that certain offenders would never be able to successfully return to their home situation because of its disintegrating influence.

In these cases, the halfway house might become a semi-permanent home until the offender's roots were completely fastened so he would not "slip back".

ONE OF THE RECOMMENDATIONS WAS THAT A V.R.A. GRANT BE OBTAINED TO STUDY THE NEEDS FOR A COMMUNITY PROGRAM TO SERVE PERSONS WITH BEHAVIORAL DISORDERS; THIS GRANT SHOULD SURELY INCLUDE THOSE PROBATIONERS WHOM WE MENTIONED IN THE FIRST PARAGRAPH. Many thought that, although many of the problems are different, many probationers without the proper programs and guidance would one day themselves become prisoners and intensify their already serious problems. There were no definite suggestions as to what form this grant should take, only that the newly formed Corrections and Vocational Rehabilitation cooperative program be instrumental in drawing up such a proposal.

The other recommendations of the groups are listed below with comments when indicated. These recommendations have been duly considered by the group.

1. A COMPLETE EVALUATION PROGRAM IS NEEDED FOR THE MENTALLY RETARDED OFFENDER. THIS SHOULD NOT STOP WITH THE TRADITIONAL INTELLIGENCE TESTING BUT SHOULD MOVE ON TO THE OTHER IMPORTANT AREAS SUCH AS SOCIAL, EMOTIONAL, AND PHYSICAL.

2. COMMUNITIES NEED TO DEVELOP PROGRAMS FOR AFTER CARE AND PRE-INSTITUTIONAL CARE. THE VOCATIONAL REHABILITATION AGENCY SHOULD ATTEMPT TO BECOME A PART OF THE "BROAD" TREATMENT SEGMENT: MENTAL HEALTH, FAMILY COUNSELING, WORKSHOP UTILIZATION, HALFWAY HOUSES, ETC. THIS SHOULD INCLUDE A *COMMUNITY BASED* VOCATIONAL REHABILITATION WORK PROGRAM WHILE THE OFFENDER IS STILL IN THE INSTITUTION. NO RELEASE PROGRAM CAN BE EFFECTIVE UNLESS THE BACKGROUND WORK HAS BEGUN WHILE THE OFFENDER IS STILL INCARCERATED. IT IS THOUGHT THAT ONE COORDINATOR FOR EACH THREE COURT DISTRICTS, WORKING IN CONJUNCTION WITH CORRECTIONS COUNSELORS MENTIONED IN THE NEXT ITEM, COULD PROBABLY HANDLE THIS PROGRAM.

3. THERE SHOULD BE SPECIFIC JOB DESCRIPTIONS SET UP FOR POSITIONS OF CORRECTIONS COUNSELORS; THESE PERSONS SHOULD HAVE INTENSIVE IN-SERVICE AND PROFESSIONAL TRAINING WHICH COULD BE MADE AVAILABLE THROUGH THE DEPARTMENT OF CORRECTIONS AND/OR THE STATE'S UNIVERSITIES. BESIDES THESE, *ALL* VOCATIONAL REHABILITATION COUNSELORS SHOULD HAVE A GENERAL ORIENTATION IN CORRECTIONS AND THE PUBLIC OFFENDER. IT WAS THOUGHT THAT ONE COUNSELOR FOR EACH OF THIRTEEN JUVENILE INSTITUTIONAL SETTINGS PLUS TWO COUNSELORS FOR EACH OF THE THIRTY-THREE COURT DISTRICTS WOULD BE SUFFICIENT TO HANDLE THIS PROGRAM.

4. ONE OF THE RECOMMENDATIONS THAT VOCATIONAL REHABILITATION PROGRAMS BE MORE CLOSELY PLANNED WITH CORRECTIONS PEOPLE HAS BECOME A REALITY WITH THE RECENT COOPERATIVE AGREEMENT ENTERED INTO BY VOCATIONAL REHABILITATION AND THE NORTH CAROLINA DEPARTMENT OF CORRECTIONS. PERSONNEL HAVE NOT YET BEEN SELECTED SO, AT THIS TIME, THE GROUP IS NOT ABLE TO REPORT ON PRELIMINARY WORK.

5. A FINAL RECOMMENDATION STRESSED THE NEED FOR THE VOCATIONAL REHABILITATION AGENCY DEVELOPING GREATER PATIENCE IF THE WORKSHOP PROGRAMS ARE TO BE EFFECTIVE WITH PERSONS EXHIBITING BEHAVIORAL DISORDERS. THE WORKSHOPS IN THIS STATE ARE GEARED AT THE PRESENT FOR THE MENTALLY RETARDED AND SOME OF THEM ARE FULLY PRODUCTION ORIENTED. FOR A RELEASED OFFENDER OF NORMAL MENTALITY TO BE PLACED IN EITHER OF THESE SITUATIONS COULD BE DISASTROUS BECAUSE OF HIS OWN SPECIAL PROBLEMS AND THE NEED FOR UNDERSTANDING.

We have had many good minds working for the Public Offender Task Force and we are quite certain that their recommendations and suggestions will not go unnoticed; they are the experts in North Carolina in their area of the public offender and, with their continued support, the offender program in North Carolina will be taking giant steps from here on.

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REPORT OF THE PULMONARY DISEASE TASK FORCE OF THE NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION

The Pulmonary Disease Task Force unanimously agreed that chronic and recurring pulmonary disease is a problem of significant magnitude to warrant attention as a rehabilitation problem. It is hoped that an orderly process can be established for the patient from diagnosis through treatment and rehabilitation to his return to a useful place in his community.

Rehabilitation of pulmonary disease falls into two major areas: (1) Long-term patients with respiratory disease such as tuberculosis, often requiring a long-term hospital stay; (2) Short-term chronic patients with respiratory diseases such as emphysema or silicosis, requiring short-term hospital stay, but recurring hospital visits. Rehabilitation differs with these two groups.

1. The hospitalized tuberculosis patient—

Usually the length of stay of this patient offers excellent opportunity for his education as to the nature of the disease, his prognosis and capabilities. It offers opportunity while hospitalized to meet and work with a vocational rehabilitation counselor and to begin plans for future activities.

Ofttimes the TB patient presents a difficult problem of after-care. If he has no adverse feeling, no temperature, and is simply on drug therapy, the decision must be made as to whether or not his disease really constitutes a disability. He may be satisfied to remain physically inactive. His rehabilitation program needs to be a joint decision of interested personnel. If his disease produces a disability, the TB patient greatly benefits from meeting his rehabilitation counselor in the Sanatorium and having the same counselor follow him when he returns to his community and assist him in returning to the working force.

The Pulmonary Disease Committee has made several recommendations regarding the Tuberculosis patient and his rehabilitation:

1. That there be adequate follow-up from the Sanatorium into the home.
2. That the Welfare Department be notified before indigent patients are released.
3. That the Welfare Department be prepared to assist the patient, if needed.
4. That the patient be cared for under a supportive program from the Welfare Department until he is re-established in his work and is able to feel secure in a job.
5. It was felt that patients receiving public assistance might be better motivated to raise their own level of living if they could keep some of the money they earn without losing their welfare check until they are physically and emotionally able to accept the responsibility.
6. That there be monthly joint agency conferences with Welfare, Health Departments, TB Association and Vocational Rehabilitation to analyze individual respiratory disease problems and to set policies.
7. Submit to physicians the importance of referring most patients to the Sanatorium for treatment. (This environment is conducive to patient education and rehabilitation, as well as treatment.)
8. That a continuing education program in respiratory disease be established and maintained. (This subject is treated in more depth later in the report).

9. Existing facilities in the community—such as sheltered workshops—should be fully utilized in the rehabilitation of patients.
 10. Use of sheltered workshops should not be limited to mentally retarded, but training in diversified occupations should be developed to offer assistance to the RD patient.
- II. The patient with Chronic lung disease (Emphysema) creates a real problem in rehabilitation.
1. Early diagnosis is essential as the patient needs to be rehabilitated before he becomes debilitated.
 2. Community programs in early detection and screening for respiratory disease are needed. (These can be planned and executed through agency cooperation.)
 3. Physicians should be motivated to refer patients early for rehabilitation.
 4. Since training of physicians in pulmonary disease is noticeably absent in some medical schools, medical schools—should be encouraged to offer more training in respiratory disease.
 5. Communities must be alerted to the need for adequate diagnostic and treatment facilities in the field of respiratory disease.
 - a. For advanced patients, there is a need for a center for immediate treatment, education, and vocational training.
 - b. Existing facilities available for treatment should be utilized.
 1. Sanatoriums should be encouraged to become identified with total respiratory disease treatment. Policies regarding acceptance need to be made public.
 2. Establish respiratory disease centers for intense specialized treatment and training of medical and paramedical personnel in the medical schools of North Carolina.
 - c. Existing facilities should be used for rehabilitation.
 1. Sheltered workshops in communities should be broadened in scope and used for pulmonary “cripples”.
 2. Chest Clinics should provide information on rehabilitation.
 - d. Develop policies to rehabilitate RD patient to care for himself; thus releasing spouse to work or rehabilitate spouse to earn income for the family.
 6. Remove the age limitations on rehabilitation. Only children with cystic fibrosis now receive assistance; other pulmonary cripples have no place to turn.
 7. Remove the word “vocational” and make it simply *rehabilitation for all persons*.

In order that earlier diagnosis may be made, the process of the respiratory disease slowed or stopped, the period of non-productivity reduced, and the rehabilitation effort be initiated earlier, it is recognized that a continuing comprehensive educational respiratory disease program needs to be initiated immediately.

1. By way of a continuing education program, physicians would be better equipped in the recognition, diagnosis, and treatment of respiratory disease. This type program would not be limited to diseases themselves, but would identify treatment facilities to which the patient could be sent for assistance; i.e., the sanatoriums, hospitals, or other treatment centers. Here the patient would receive information regarding his rehabilitation as an integral part of treatment.
 - a. This type program may be planned by a joint committee with representatives from the 3 schools of medicine, 3 State Sanatoriums, VR Personnel, TD & RD Association Staff, and interested physicians and laymen.

- b. Such a program would be available to every physician across the State and the physicians would be strongly urged to utilize this service.
- II. Continuing educational programs should be established for all disciplines dealing with diagnosis, treatment and rehabilitation of RD patients. This would result in better referral by way of:
 - a. Nurses—especially PH Nurses, hospital, private duty
 - b. Social workers—Welfare Department and hospital based
 - c. D.V.R. workers
 - d. TB Association workers
 - e. Sanatorium staff(All personnel that come in contact with the patient.)

SUMMARY of RECOMMENDATIONS:

1. Rehabilitation services should be available in places where pulmonary disease patients are: Sanatorium, hospital, clinics. (Include patients with diseases such as asthma, emphysema, as well as tuberculosis).
2. Private physicians should be made aware of services available and motivated to refer patients for rehabilitation and retraining before they become severely debilitated.
3. The public could be made more aware of rehabilitation services through wider use of mass media. (Radio, TV, newspapers.)
4. Joint agency conferences should be held to facilitate wide community planning and faster and better referral.
5. Joint agency programs could be developed for early detection and screening programs.
6. A program of continuing education in pulmonary diseases should be encouraged for medical and para-medical personnel, beginning in the hospital and carrying through into the community.
7. Vocational rehabilitation should broaden its base to include rehabilitation of persons in a wider age group.
8. Existing facilities should be utilized in the diagnosis, treatment, and rehabilitation of respiratory disease patients where available. Facilities should be extended where the need indicates.
9. The Vocational Rehabilitation Department would serve a more useful purpose if it would extend its activities to include a patient's vocational training and personal, or family rehabilitation.
10. The VR counselor is a great asset to the TB patients in the Sanatorium to assist them in their return home. This program should be continued and enlarged. The counselor should not limit his service to tuberculosis alone, but should work with patients with all types of respiratory diseases, i.e., emphysema, asthma, etc.

**REPORTS OF THE
REGIONAL CITIZEN'S COMMITTEES**

**COASTAL
MOUNTAIN
PIEDMONT**

Most of the material used by the regional advisory committees for their reports came from a series of public hearings which each committee conducted. This section begins with a summary of all public hearings. This summary is followed by the individual committee reports and representative summaries of some of the hearings conducted.

The following is a summarization of testimony received by various members of the Regional Citizens Advisory Committees in public hearings which have been held in Rutherfordton-Spindal, Cullowhee and Durham. These hearings were held on April 10, April 18 and April 24 and 25, respectively. By the way of general information, other hearings have been planned for Salisbury at the Rowan County Sheltered Workshop on May 15, in Charlotte for May 30 and 31 and in Montgomery, Moore or Richmond Counties at a date still to be set. On May 8 a meeting of the Coastal Regional Advisory Committee is planned for Greenville at which time we anticipate the formation of plans to conduct four public hearings in the Eastern part of the State.

The hearings held in Rutherfordton and Cullowhee were attended by representatives from many state and local service agencies. Testimony has been heard from workers from various county Departments of Public Welfare, Departments of Public Health, Departments of Mental Health, the Employment Security Commission, Public Schools, Manpower Development Programs, Technical Action Panels, Federal Probation and Paroles, Bureau of Indian Affairs, State of Franklin Project, former clients of the Vocational Rehabilitation Agency and social agencies and interested individuals. Testimony in the Durham hearing was given by representatives from local sheltered workshops, the Better Health Foundation, Duke University School of Medicine, Employment Security Commission, Society for Prevention of Blindness, Durham Rehabilitation Houses and interested citizens.

Testimony which was given in all three of the public hearings has had an amazing degree of commonality. In particular, the hearings held so far in the Western part of the State have begun with and had a continuous reference to a lack of communication between social agencies. This lack of communication leads to a failure to fully utilize resources that are available. It also seems to discourage referral and joint agency work with needful individuals. A great deal has been said about the need for agencies to inform referral sources as to action taken on a referral or the result of services provided a referred client. In this same vein, concern has been expressed many times by different people about lack of follow-up with persons who have been provided services. The suggestion was made that a failure in this area many times negates the value of services rendered. The rehabilitation counselor, according to testimony received, has an image among his social service peers as being a dedicated, cooperative, friendly person but one who is harassed by the volume of work expected from him and the large geographical territories for which he is responsible. This image which is fostered by the sight of large numbers of people who come to see the itinerate rehabilitation counselor seems to discourage other agencies for making the numbers of referrals that might be profitably made. It has been revealed that the rehabilitation counselor seems to have a very limited amount of time to work with individuals who need his help. When visiting a county away from his district office, he often works at a constant pace throughout the day and even then can spend only fifteen minutes or so with each individual. Because of these factors and because other social agencies feel that they do not know what criteria the rehabilitation agency uses in selecting clients, each agency seems to be highly selective in regard to the people whom they refer to the Vocational Rehabilitation Agency. Since agencies disclaim any knowledge of Vocational Rehabilitation's eligibility criteria, it is implied that referral to Vocational Rehabilitation is largely dependent on the client's internal motivation.

From the clients who have presented themselves at the public hearing, one is led to believe that the success which they exhibit is a result of their own aggressiveness. Although all clients who have appeared in the hearing have been "successfully rehabilitated" and have been entirely positive in their attitudes toward the agency, the way they relate their story of rehabilitation makes it seem clear that had they not been motivated they would have more than likely never seen a vocational rehabilitation

representative beyond their initial encounter. Although the clients have not been critical regarding this point, it was interesting that each client was offered identical training courses during his first encounter with the rehabilitation counselor. None of the clients accepted any of these training programs and they left their first interview feeling somewhat despondent about possibilities for gaining help through the state agency. Fortunately, the referral source who had established the original contact between the client and Vocational Rehabilitation and the client's own motivation was strong enough that a subsequent contact with vocational rehabilitation was held and the rehabilitation process initiated.

Particularly in the Western part of the State there seems to be an outcry from the various community agencies that Vocational Rehabilitation should become more of a community based agency rather than an agency who provides itinerate services in that area. A specific recommendation was made in one hearing that there should be a Vocational Rehabilitation office assigned to every county with a population of at least 30,000 people. When the person who made this recommendation was questioned regarding a reason for this specific figure he used, he indicated that he had used this figure since his county would fall in that category and he was convinced that his county needed the full-time service attention and effort of at least one vocational rehabilitation counselor for the general rehabilitation program in that area. No witness from an organization other than Vocational Rehabilitation has failed to indicate their feeling of need for twice as much or more counselor time than they are now receiving. Other problems mentioned in connection with this manpower shortage is that itinerate counselors do not appear to have enough autonomy to function effectively in a rehabilitation counselor's role. Many dissatisfactions were voiced regarding the necessity for the counselor to clear with the district office before a decision could be made or his involvement in a community program could be initiated. Concern has been expressed about the personnel turnover in the Vocational Rehabilitation Agency. County representatives indicate that of recent, it is not at all uncommon to work with five or six different counselors per year. These changes obviously disrupt clients progress through the rehabilitation process. Although all social agency personnel expressed sympathy toward vocational rehabilitation persons as well as themselves for the amount of paper work involved in processing cases, the adequacy of case recording was questioned since it seems that each new counselor has to almost begin the rehabilitation process all over with the cases he inherits instead of being able to simply take a case from where it is at the time he assumes responsibility for it. Other factors mentioned as problems dealt with the fact that the counselor's infrequent short visits often had to be interrupted so that the counselor could participate in conferences and in-service training programs. A need for in-service training activities to be brought to the community was verbalized.

Other problems dealt with in the public hearings concerned a shortage of realistic training opportunities and the need for more careful vocational rehabilitation diagnosis. There seems to be a rather common problem being presented which indicates that training which is provided to clients is often outdated and inappropriate unless the client is willing to move his home area. Many people seem to feel that the Vocational Rehabilitation Agency, technical institutes and community colleges should establish a much closer working relationship and work together in designing training programs more specifically designed for job opportunities in the area from which a client comes. Transportation has been specified as an almost insurmountable problem to many severely handicapped people and persons with a marginal motivation for self-improvement. The hearings have suggested the need to closely scrutinize this problem so that we can try and develop live-in facilities where needed and provide workable transportation plans where such are feasible.

There has certainly been great concern over the financial difficulties of the vocational rehabilitation program. From the testimony given, other agencies see perennial fund shortages as not only affecting the immediate caseload of the Agency, but as negatively affecting the cooperation and coordination between Vocational Rehabilitation and other social service agencies and groups. There has certainly been no implication that there has been any mishandling or misappropriation of funds for case services, but there has been both explicitly and implicitly in testimony an idea that the Vocational

Rehabilitation Agency's financial planning is poor and there has been both explicit and implicit suggestions that available vocational rehabilitation funds be divided among the various areas of the State on an impartial basis rather than on a first come, first served arrangement.

Although there has not been any hesitancy on the part of persons participating in public hearings to candidly discuss rehabilitation problems as they see them, there has not been any indications of animosity toward the Vocational Rehabilitation Agency or any other community agency or organization. All criticism in testimony has been for the most part very positively and constructively given. Each hearing will be written up individually in more detail than the present report. It is felt that much valuable information is being derived from the hearings and although the purpose of the hearings is not informational, we feel that a great deal of information is being disseminated among those who are participating. At a later date, when all hearing locations have been selected, dates set and sites for the hearing picked, you will receive this information and we would solicit your making arrangements to attend one of these very exciting sessions.

Since the above summary of the public hearings was originally prepared, other hearings were held in Salisbury, Charlotte, Goldsboro, Elizabeth City, Greenville, New Bern, Elizabethtown and Fayetteville.

The material presented at these additional hearings was quite similar to the testimony given in the hearings previously reported. A great deal of concern continued to be expressed concerning a lack of information among agencies regarding the Vocational Rehabilitation Agency's service programs. In these additional hearings, the primary concern was centered around a lack of interagency communication.

The main difference between the hearings held in the East and those held in the West and in the Piedmont was that much more probing was required to get hearing participants to identify and discuss problems with which they are being confronted. There was also much more discussion in the east regarding the earlier identification of handicap and provision of service to children before school age. The agencies in the east further indicated from their testimony a feeling that the eligibility requirements for vocational rehabilitation were so stringent that they should be relaxed in order for the agency to be of more service to the community.

In the Elizabeth City hearing as was also true in the Durham hearing, much discussion was directed toward the role that the Rehabilitation Agency might play in regard to providing programs for the aged. It was reported by representatives of the Health Department and Welfare Department that numerous of their elderly clients were quite good in handicrafts and that if it were not feasible to further develop workshops in the east it would be extremely helpful to develop a marketing procedure in order to help these individuals sell their products. It was also felt that vocational rehabilitation could provide tools and equipment that could very well help these individuals increase their production, thereby, supplementing their income so that they could have a more adequate standard of living. Also characteristic of the hearings in the East was a concern regarding the development of facilities—medical, workshops and community mental health centers that are presently non-existent in that area of the state.

The hearings in the West, Piedmont and Coastal Plains present some very interesting contrasts. No staff work was required to plan or develop the public hearings in the West. Some staff involvement became necessary in the Piedmont section of the state and a great deal of staff time, effort and direction was required to have the hearings in the East. Generally speaking it seems that people in western North Carolina are much more acutely aware of their program gaps and the needs of their citizens than in any other section of the state. In the Piedmont there are so many activities and programs that very little time is taken to coordinate or communicate with other service programs. Agency people in Eastern North Carolina seem to be aware only of the most obvious problems which exist in their population and they are unaware of the more subtle difficulties encountered in coordinating multiple service programs.

REPORT OF THE COASTAL REGIONAL ADVISORY COMMITTEE

This report has been designed to follow the format suggested in Mr. Morrow's most recent memorandum. There has been no editing of the group's findings, therefore, some will be repetitious.

This report to the study committee should be considered a preliminary report, and essentially a digest of what will be a more comprehensive report. This will be completed as the Coastal Advisory Committee meets once again to complete its work with a final review of findings and writing its formal report, including recommendations.

The Coastal Committee concerned itself with looking at the needs of rehabilitative services in the region and proposals to meet the needs where necessary. It sought to accomplish these purposes by assessing the current programs, services, identifying gaps and/or barriers within the rehabilitation process. Its vehicle for accomplishing the purposes was the public hearing. Thus, six public hearings were held in eastern North Carolina. Participating, in addition to committee members, in the hearings were people from all segments of our society. Business, governmental agencies, private agencies, individual citizens, medical profession, legislators and the ministry were well represented. Many views were shared, some "debates" arose; but once a dialogue began between the hearing panel and the audience, the sincere interest of those assembled was evident, and contributions were made. Regretfully, a key group, the past, present, and potential recipient of services was lacking in attendance. Only a few attended.

The following is a summary of findings from which the committee will make recommendations which will afford a more effective, and expanded program.

- (1) Communication
 - a. How is the public informed?
 - b. Inter-agency relationships
- (2) Rehabilitation of alcoholics
- (3) Earlier use of rehabilitation in services in schools
- (4) Counselors caseloads too heavy
- (5) More counselors
- (6) Better salaries
- (7) Time lag from initial contact to initiation of services
- (8) Housing—related to training in a sheltered workshop
- (9) Determination of eligibility
- (10) Rejection rate statistics—by referral group
- (11) More concentration in job placement
- (12) New training programs *re* specific jobs—Ex: Agriculture
- (13) Outreach aspect—use of volunteers to inform and transport
- (14) No comprehensive multi-service rehabilitation center
- (15) Funding request to legislature "lost" in total Department of Public Instruction budget.
- (16) Innovations carried out—Special program at O'Berry cited

- (17) Progress in better coverage—Geographical
- (18) Is there or isn't there a closing quota system?
- (19) Citizens' Advisory groups—needed
- (20) Transportation

Tentative Recommendations

- (1) Reduce caseloads
- (2) Higher salaries—Encourages those who want to serve as counselors to do so—and not be forced to become administrators
- (3) Discuss with appropriate agencies a consolidation of services in regard to early treatment of school children
- (4) Establish advisory groups which will assist in interpretation and fund seeking
- (5) Make use of non-professional staff feasible
- (6) Seek ways to continue present study committee
- (7) Create, if necessary, a Public Information Officer position. If not then assign a talented member to develop this aspect of the program. Take it to the people. Explain the program.
- (8) Dramatize Division of Vocational Rehabilitation. Make it visible within Public Instruction.
- (9) Study feasibility of becoming separate, part of another agency, and/or more important within Public Instruction.
- (10) Cooperative of study with others to seek to work with the alcoholic, deaf, and socially deprived
- (11) Be aggressive

FINAL REPORT

OF

MOUNTAIN REGIONAL ADVISORY COMMITTEE

NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION

The Mountain Regional Advisory Committee was formed to be a part of the North Carolina Study in Vocational Rehabilitation.

On December 6, 1967, the first formal meeting of the group took place. At that meeting, Mr. Joe Morrow, Planning Director for the study project, presented the purposes and goals of the North Carolina study, and apprised the group of the various possibilities in which it could function in order to be helpful to the statewide study. Decision was made to establish task forces within the mountain group, and to proceed simultaneously with plans to hold a number of public hearings. It was decided that the Mountain Regional Advisory Committee would meet quarterly, with a final summary meeting on October 17, 1968.

The plans outlined above have been followed. Consequently, I am reporting to you generalizations, and perhaps certain specifics, that have come before the committee to this date. Obviously, this report is not complete, as our summary session is some two weeks off.

I believe that Mr. Morrow can attest to the fact, having attended the group's meetings, that the enthusiasm reflected in the attendance and discussion must be marked down as a "*plus*"—even if nothing further is accomplished. It has been particularly rewarding for those of us who work in some aspect of rehabilitation, in the broadest sense of the word, to see how interested the public can become in participating and planning for rehabilitation services when given the opportunity.

Perhaps I should mention that the most constant comment throughout the meetings and public hearings has been related to just this, i.e., very few people in the general public are aware of the rehabilitation services that do exist; and even more noteworthy is the fact that very few people within agencies related to vocational rehabilitation have much of an idea as to its goals, its criteria for services, its ability to give service, or the needs that must be met if services are to be strengthened and expanded.

Let me re-emphasize that the Mountain Regional Committee feels that lack of knowledge of vocational rehabilitation on the part of almost everyone concerned is certainly the largest problem, the most serious problem, and obviously, the one that we feel needs first attention.

In order to get back into the proper sequence in relating our experience, I should report that there has been good attendance at the quarterly meetings, and as far as I can tell, a fair amount of task force work between meetings.

The Mountain Regional Committee is made up of fifty-three persons from the western third-or-so of the state, and contains social workers, business administrators, directors of departments of public welfare, a sheltered workshop director, bankers, ministers, several physicians, attorneys, private industry personnel representatives, psychologists, school superintendents, recreators, an architect, housewives, mental health center administrators, industrial executives, a caseworker for the blind, specialized rehabilitation persons, reporters, and others.

The committee has been concerned that it has little representation from the far western counties, and very little representation from the northern mountainous counties.

The task forces consist of a combined mental health-mental retardation-cerebral palsy task force; a task force on aging; a vision task force; a task force on alcoholism; a combined manpower training-communication-public relations-education task force, a task force on architectural barriers, finances and legislation; and a rehabilitation workshops and facilities task force.

The committee has been particularly helped by the presence of a member of the State Board of Education; attendance regularly by Mr. Joe Morrow, the Planning Study Director; and a presentation and discussion by the State Director of Vocational Rehabilitation, Mr. Claude Myer.

After considerable discussion and planning, the committee decided to hold public hearings in Rutherfordton, Cullowhee, and Salisbury. Although the format for these meetings was similar, it turned out that the meetings were a bit different. At Cullowhee, the participating agencies and interested persons as a group met together throughout most of the day. At the other two public hearings, the panel appointed by the committee heard presentations, discussions, and questions on a scheduled basis from interested parties.

The public hearings were deemed by the committee to be highly successful, and there seemed to be no shortage of people who wished to participate. Various agencies quickly saw a need to give the hearings high priority, and consequently, seemed to be not only interested in, but quite involved in the discussions and proceedings.

At each hearing, some clients who had participated in a rehabilitation program came and added valuable testimony.

As helpful as the public hearings were, the content of the hearings was not remarkably different from the discussions that had taken place in the committee meetings. This, of course, does not mean that the committee's function could have taken place of the public hearings. Indeed, our short experience has indicated that the reverse might be true.

I should mention again that the most important finding has been the lack of knowledge on the part of the public and involved agencies as to the function and services of vocational rehabilitation. Second to this is a problem voiced over and over again: the need for communication between agencies and vocational rehabilitation. Agencies felt that many clients were being denied vocational rehabilitation services who should have received such services. This lack of depth in communication seems also to include the need for follow-up for those clients accepted for services. It became obvious in the hearings that many people are referred to vocational rehabilitation through the departments of public welfare. Indeed, many people think that vocational rehabilitation is a part of the services offered by the Department of Public Welfare.

Following close behind the need for education and communication, comes the need for additional manpower in the field. On several occasions, the statement was made that, "we need at least one vocational rehabilitation counselor in a county of 30,000 people". Part and parcel of the manpower shortage, at least as others see the current services performed, is the fact that there is too much "starting over", as it was phrased by several persons in one public hearing.

It was brought out at that hearing that it was not unusual for the "turn over" of counselors to mean that one county or area would see several new faces within a year's time. This discussion usually led to the need for more adequate salaries, which might also bring greater numbers of trained counselors.

According to those who participated in the public hearings, it seemed obvious that the clients who did receive help received it partially through being aggressive and highly motivated. One would presume that many of the clients who did not possess these qualities are among those who are not being served at present. Clients who had received services commented on several occasions that vocational training offered in a particular area needed to be more nearly tailored to the area's specific manpower needs.

Many persons, during both committee meetings and the public hearings, commented on the fact that counselors in the field now seem to be so overwhelmed with "paper work" that on occasions in visiting an area as part of their itinerary, they find a full waiting room, and, consequently, must parcel out their time in fifteen-minute intervals. Clerical duties described tend to give the impression that the counselor is more "office oriented" than "people oriented", according to comments at one public hearing.

Involvement of vocational rehabilitation with public schools came up for considerable discussion. Problems in this relationship centered around the counselors' need for experience in this specialized area, as well as the feeling on their part that their work in this area was not well-defined.

Some expressed the feeling that the schools had not properly prepared the students to participate with the counselors. Of major importance was the fact that the counselors did not have the time to work with the parents of the students involved. The lack of time to work with parents points up the whole area of family involvement in the process of vocational rehabilitation. Feeling runs strong that the agency must either strengthen itself with the addition of social workers, or provide more adequate training for its counselors, if the approach is to be broadened to include rewarding involvement with the client's family. As I am sure you are aware, rehabilitation efforts for younger clients can be most frustrating for all concerned if the family is not involved in the process. Recommendations were made for the establishment of closer and better communications between agencies whose primary work is that of family involvement (departments of public welfare, family service agencies).

With the awareness that increased vocational rehabilitation services may, at first, increase many of the problems touched upon, there has been a general concensus throughout the meetings and hearings that the depth of involvement, or better said, the initiation of vocational rehabilitation into the life of a client, must take place earlier! This seems to be particularly true in the problems that tend toward chronicity: mental retardation, mental illness, blindness, deafness—to name only a few, literally cry out for the need for earlier intervention. (One cannot use the phrase, "cry out", without being forced to realize that the rehabilitation process must someday start in the newborn nursery!).

Intervention seems not to be timed on the basis of a need or readiness to work. Perhaps work itself is of least importance in helping the client to make a lasting adjustment in day-to-day living. Earlier intervention, obviously, takes us to the childhood of handicapped persons. Play is the language of childhood. Consequently, vocational rehabilitation must look closely at this area, the area of pre-vocational readiness, and perhaps use new tools and procedures, in order that more people can receive services, at least in the formative years, in order that their handicapping condition can be approached earlier—before the handicap becomes an essential part of the person's life and personality.

Play is important to children as a means of pleasure and communication, which takes us to another recommendation from the mountain group. That is for the study of the possibilities that therapeutic recreation might offer to total rehabilitation planning. If the client is unable to make his leisure time a time of satisfaction as he learns to live with himself and with others, then the progress made toward his rehabilitation may be lost.

Soundness in the area of pre-vocational evaluation and early intervention, hopefully, will lead to more handicapped persons finding their way into the mainstream of rehabilitation services. Consequently, this whole area of pre-vocational involvement can be labeled as *Preventive Services* in the best sense of the term.

In closing, I should like to briefly summarize our tentative findings:

1. There is a need for education on the part of the public and of agencies as to the goals and services of vocational rehabilitation.
2. There is a serious need to strengthen communications between vocational rehabilitation and the agencies with which it works.
3. There is immediate need for additional manpower in the field, with greater depth and training available, and salaries more appropriate for professional personnel in the rehabilitation field.
4. Vocational training offered should be more specified to the needs of particular geographic areas.
5. Additional clerical help should be provided, in order that the counselor can spend more time with his clients, and less time with "paper work".
6. Perhaps more inservice training should be provided counselors who are involved with the public schools, and joint meetings held with the public schools to constantly evaluate that experience.

7. Additional expertise should be brought to bear on the involvement of parents and relatives in the client's vocational rehabilitation program.
8. A closer working relationship, which hopefully would bring additional support for family involvement, should be established with agencies whose primary work is with families.
9. There is a real need for earlier intervention by vocational rehabilitation into the life of a handicapped person. Intervention must take place as early as the handicapping condition is found.
10. There should be exploration of the possibilities of recreation as a means of not only providing a means of rehabilitation, but as an agent that may make the vocational rehabilitation program a more lasting success.
11. Last but not least, there should be a continuation of involvement of vocational rehabilitation with other agencies, and particularly with the general public, in planning rehabilitation programs, i.e., a continuation of groups similar to the one in which I have had the pleasure of participating.

J. Iverson Riddle, M.D., Chairman
Mountain Regional VR Advisory Committee

**REPORT OF THE PUBLIC HEARING FOR
MOUNTAIN REGIONAL ADVISORY COMMITTEE OF
NORTH CAROLINA STUDY ON VOCATIONAL REHABILITATION
HELD AT CULLOWHEE ON APRIL 18, 1968**

The site of the hearing was in Room 103 of the Killian Building, Western Carolina University on April 18, 1968. This report is a resume of topics discussed. It in no way follows the order of discussion from the floor, nor does it imply particularly the length of discussion of any one topic. Rather it is the interpretation by one panel member of subject matter discussed.

There seemed to be mentioned at several points throughout the day the need for community lines of communication. It was felt that if one agency knew what another was doing, in work with a problem family, that frequently the total resources might be applied with greater therapeutic effect. Planning agency was discussed. Interagency conferences were discussed. These seemed to be ways in which prevention of loss of patients through referral cracks might be brought about. Further, each agency could then extend its most effective area of work toward the total habilitation of the family. OEO worker described that his office has frequently followed patients through referral channel to see that they reached the proper agency and at the proper appointment time. A social service exchange was briefly discussed. It was the general feeling that this had once been tried but was actually an ineffective avenue, but perhaps one that might be improved to become an effective mechanism.

A strong point was made that the earlier identification of problems in people's lives might be beneficial. It would seem that if we worked with the problems when they first arise, that there might be a greater chance of dealing with issues. It was generally desired that the earliest possible identification be made. This type of discussion led to thoughts about "habilitation" as opposed to rehabilitation. It brought up the issue of the definition of priorities for the Department of Vocational Rehabilitation. No one seems to know what definition of priorities had been made within the department.

Vocational Rehabilitation within the educational system was discussed. It was felt that case findings should extend to pre-school level. Developmental needs of the child were to be estimated. This led to discussion of special education needs such as speech therapist. It was felt that in the area there was a need for one speech therapist per 10,000 people. There was noted a high relationship of speech defects to reading defects. Though there was use of rehabilitation counselor for special education groups, it was felt at present to be too limited. The rehabilitation counselor should consider a more varied expansion in training for clients. It was felt that there was a large effort to carry out occupational training for work that was not realistically available to the local scene in the work world. Considerable discussion was held about educational differentiation. It was generally felt that all youngsters were being exposed to the same process when more individual needs should have been estimated and met.

There was a recognition of many social problems in deprivation. Workers who deal with people caught in the deprivation web should have understanding of the meaning of the experience of living. The worker should be more "human oriented rather than office oriented." Sheltered environments were desired. Day care needs should be evaluated and programs established. Though Sheltered Workshop is available, frequently its usefulness is curtailed by such problems as "no funds" available. Many of these programs have limiting age implications. The question of what age does training begin was brought up. The state payroll merit system was discussed. Adequate pay would tend to keep counselors longer in the occupation. They seem to change too fast, so that patients frequently have to re-tell their stories over again to new counselors, and so lose interest in the rehabilitation program. It was felt

that one worker should be available for every 30,000 population. The group wondered if there were administration problems that lead to funds expiring before new bi-annual appropriations were made. Had the state utilized all of the available federal funds adequately? Had medical fees been kept in keeping with the usual going medical rates so that the sector of society was kept interested in accepting the rehabilitation patient? A question was raised about the Mental Health eligibility of that group of patients. Had they always been accepted for instance with the same interest as physically impaired problems that could be rehabilitated?

Training was discussed. Training was divided into two sections: One for the worker. There was concern that perhaps there should be a new shift of emphasis. How about incorporating educational and social needs of likely recipients. Is an industrial therapist actually needed? Has training experience led to adequate cooperation with other programs and has the training been directed so that the counselor renders both direct and indirect services in the community? Some felt that it wasn't particularly the numbers of workers that were needed in the area, rather that their use should be altered.

Secondly, training was discussed regarding patients. It was felt that there was in the local community a strong link with community college and industrial institute, but that this should be broadened.

Community education was considered in which Vocational Rehabilitation as a service might improve its self image in the general community. For instance, there was high employer resistance. It was felt as a result of lack of education, certain state laws were rather restricting and that in actuality legislators did not know of the restricting nature. There had been a general community attitude that referral to Vocational Rehabilitation was through the Department of Public Welfare. This is a rather restricted attitude and not actually a true picture. And yet, the idea persists throughout, not only general public, but many agency people. Therefore, a further need for coordination and inter-agency education. The idea was expressed that public relations person might actually be employed to carry out some of these indirect services. The program needed to be given an identity defining what it was and where its services extended. Special problems were discussed, particularly alcoholism and children services. The occupational and vocational potentials should be considered during childhood. Discussion of the predictability of school drop-out was carried out to some length. A description of local program in Haywood County illustrated that certain persons could be predicted to produce certain problems and within this group Vocational Occupation Education of special nature might be of advantage.

In regard to referral of patient it was felt that the criteria for referral was often too rigid. It was felt that the scope of rehabilitation covered greater area than apparently the department now saw fit. In a sense then, they were asking, have we identified the handicapped? They ask the question if the agency has become too structured in order to deal with the vast problem that it faced. Frequently, one of the local problems of referral dealt with the transportation of the patient. Considerable discussion revolved around follow-up of patients. Particularly interagency reporting. Duplication of services had, at times, been evident because agencies had not really faced the problem mutually.

Though this panel member had attended another meeting, certain similarities were seen. However, unique areal problems to the Western section were noted.

Trevor G. Williams, M.D.
Chairman

**REPORT OF THE PUBLIC HEARING FOR
MOUNTAIN REGIONAL ADVISORY COMMITTEE OF
NORTH CAROLINA STUDY ON VOCATIONAL REHABILITATION
HELD AT SALISBURY ON MAY 15, 1968**

Panel Members:

Richard C. Parker, Chairman
Tom Lane
Elmer Crawford
Edna S. Stockton

Mr. James Blakely, who was also to have served on the panel, was unable to attend due to an accident in his family. Mr. Joe Morrow, Planning Director of the North Carolina Study in Vocational Rehabilitation, was present. Mrs. Sarah Bray, who did an outstanding job in arrangements, was present along with a number of other persons.

The chairman gave a brief opening statement, and the first person to testify was a representative from the Salvation Army in Salisbury, who stated he was there to learn more about the services of Vocational Rehabilitation and how these agencies might assist each other.

Members of the Rowan County Welfare Department appeared during the morning, and stated they had a good working relationship with Vocational Rehabilitation. However, the Welfare Department made note of the large case load a counselor has to carry, plus the slowness in picking up referrals.

One school guidance counselor felt the Vocational Rehabilitation Counselor Program in the school system was too new to be evaluated fully at this time. However, it was the feeling that the program was good, but that more communication between counselor, student, and school guidance counselor was necessary.

One school guidance counselor stated several problems their school had experienced with the new Vocational Rehabilitation programs:

- a. Lack of any planning and orientation for the Vocational Rehabilitation Counselor. Just suddenly appeared one day—the school staff had not been informed. It was pointed out that this was as much the fault of the school administration as Vocational Rehabilitation. There appeared to be no initial planning and the program was not structured.
- b. Lack of prior experience or training of Vocational Rehabilitation Counselor.
- c. The job had not been clearly defined to the Vocational Rehabilitation Counselor.
- d. The students were not properly oriented to Vocational Rehabilitation—They looked upon the Vocational Rehabilitation Counselor as the man who would get them a job to earn money.
- e. The counselor failed to work with the students' parents or family in planning a vocational program for the student.
- f. In some cases there was a lack of vocational evaluation by the Vocational Rehabilitation Counselor.

The school counselor stated that the Vocational Rehabilitation Counselor worked very hard, but the volume of paper work he was required to do was asking too much. The school counselor also stated that the Vocational Rehabilitation Supervisor expected too much from the counselor.

A Workshop director stated that he had been unable to obtain equipment for his workshop through Vocational Rehabilitation.

School Attendance Counselor for Rowan County was there to learn more about Vocational Rehabilitation and its services.

A county commissioner from Rowan County appeared in the afternoon, and from his statement and response to questions knew very little about Vocational Rehabilitation and its services. He had it confused with Rowan County School System and the OEO programs. Two members from the State Legislature also appeared in the afternoon. Their response, as well as their questions, showed their lack of knowledge about Vocational Rehabilitation and its services.

A Welfare case worker mentioned that more money should be located for dental services. She felt this was a definite handicap.

A Workshop director mentioned the following problems, but did qualify his statement by saying many of the problems of the past have been solved:

- a. That his Workshop staff spent a great amount of time doing statistical work on clients referred to the Workshop, when this is the counselor's responsibility.
- b. That the Workshop staff had been denied the use of psychological and physical examination reports by the counselor. (There may be some policy here which would prevent the sharing of such confidential reports.)
- c. That the client's training fee in a workshop is a set standard charge, but in some cases they have been paid less by Vocational Rehabilitation without explanation.
- d. That there is a great deal of counselor turnover; that the counselor is required to attend too many training sessions for fairly lengthy periods of time; and that there is too much transferring within Vocational Rehabilitation. He stated that about the time you are able to work with one individual, he either leaves Vocational Rehabilitation, is transferred, or is away for training.
- e. The problem of Vocational Rehabilitation and its payment of bills was mentioned. How this affected the community Sheltered Workshops and their working relationship with business and professional persons was also mentioned.
- f. The counselor places clients in the Sheltered Workshop; then leaves it to the Workshop personnel to find employment placement. That there is very little follow-up on the client was also mentioned.
- g. The problem of the counselor being burdened with too much paper work was mentioned by several individuals during the session.

A lady from Mocksville gave a report on what has been done in her community in reference to architectural barriers. This lady launched a most effective campaign involving the politicians, businessmen, town leaders, and others in eliminating architectural barriers. High praise was given Vocational Rehabilitation and their work with physically handicapped persons.

Mrs. Dawson read a statement from Mrs. Karen C. Yount, President of Rowan County Association of Retarded Children, who was unable to attend. (Copy attached)

Mr. Joe Morrow ended the five (5) hour session with a summarization of the day's events and this statement:

The reason for conducting hearings on the program was to find faults in the system in order to correct the mistakes made and the problems. He said the hearings were not to place the blame on any other organization. "We need to be concerned about the failures of the program rather than the good already done. If we air our problems, the program will gain more strength. The rehabilitation program speaks for itself."

My impression of the day's events were:

1. There is a need for additional Vocational Rehabilitation Counselors if the needs of Rowan County and surrounding areas are to be met.
2. The orientation and training of the Vocational Rehabilitation Counselor needs scrutiny.
3. The turnover rate, transferring, and movement of counselors needs attention.
4. A better system of communications and coordination between the State Division of Vocational Rehabilitation and the Community Sheltered Workshops should exist.
5. The services of Vocational Rehabilitation are not widely known to other private and governmental agencies in Rowan County. The elected county and state officials are not knowledgeable as to the services provided by Vocational Rehabilitation.

Richard C. Parker
Chairman

STATEMENT CALLED IN BY MRS. YOUNG

As President of the Rowan County Association of Retarded Children, I would like to point out that in planning future programs for the handicapped that it be judged not by how many forms were filled out today, nor by the number of staff members, but rather by the quantity and quality of help given to the clients our agencies are purported to serve.

This year I have met a great deal of buck-passing in dealing with state agencies, and this is usually involving programs for the moderately and severely retarded.

Parents of the trainable children were pressured to found this workshop, yet, Vocational Rehabilitation wants no part of these children although they are legally defined as trainable. Consequently, the Extended Client Program is financed through foundations. One workshop member told me that the Extended Client Program was no more than babysitting. If this is so, I do not blame DVR for not touching it. However, trainable retardates are producing all over the nation under sheltered conditions. We ran into the same problem with our profoundly retarded—no one wants them, not Day Care—not our state hospitals.

It seems every agency is willing to jump on the band wagon for retardation, but that no one is looking at the whole picture and attempting to coordinate services so that all are served, even when serving them is easy.

Karen C. Young, President
Rowan County Association of
Retarded Children

**REPORT OF THE PUBLIC HEARING FOR
MOUNTAIN REGIONAL ADVISORY COMMITTEE OF
NORTH CAROLINA STUDY ON VOCATIONAL REHABILITATION
HELD AT RUTHERFORDTON ON APRIL 10, 1968**

The Vocational Rehabilitation Public Hearing was held on April 10, 1968 in the Meeting Room of the Spindale Community Center.

The following agencies were represented:

- Rutherford County Department of Public Welfare
- McDowell County Department of Public Welfare
- New River Mental Health Center
- Cleveland County Mental Health Center
- Rutherford County Mental Health Center
- Technical Action Panel
- Rutherford County Department of Education
- Kings Mountain Department of Education
- Vocational Rehabilitation
- Sheltered Workshop of Rowan and Davidson Counties

Mr. Martin Amacher, serving as Chairman of the panel, opened the hearing by introducing the members of the panel: Mr. C. K. Avery and Mr. Bob McDaniels both from Broughton Hospital.

Mr. Joe Morrow, planning director for the North Carolina Study in Vocational Rehabilitation, was introduced. He stated that the North Carolina Study started in January, 1967. Its purpose is to look at the problems of the disabled and the effect on the population of North Carolina. They are concerned with the long range planning of how to use the resources and the need for other resources.

This study was started by forming a number of organizations trying to involve citizens in the state. The governor appointed the Governor's Study Committee. From this, three regional advisory committees were formed and nine disability task forces.

The members of this study are trying to analyze the work that the Vocational Rehabilitation agency has been doing including cooperation with other agencies. They are soliciting opinions and ideas across the state that must be solved.

This hearing is attempting to formalize the ideas of people in a particular area of problems and needs. This information will be used for planning the development of more comprehensive arrangement of community resources.

Mrs. Pat Roach, representative of the Rutherford County Department of Public Welfare, stated that she has had about a dozen cases referred to Vocational Rehabilitation in the past two years. Some have been successful, others have not. She feels that there has been no difficulty in referring a client to Vocational Rehabilitation or talking with the Vocational Rehabilitation representative; however, they are so busy that it is difficult to have a purposeful follow-up. The caseworkers are not able to talk at length with the Vocational Rehabilitation counselor when he is in the office. The counselor visits their department twice a month. When he is there, there are too many clients for him to see, both follow-ups and new clients.

The Department of Public Welfare feels that Vocational Rehabilitation does their job efficiently and as well as could be expected with the time involvement and the number of people to be seen.

The representative from the McDowell County Department of Public Welfare stated that they had at least five different Vocational Rehabilitation counselors in the last year. This involved too many changes and duplication in service. They question if this is an administrative problem? The turnover involves too much readjustment for the clients. When a new Vocational Rehabilitation counselor takes over, he must start at the beginning with each client. This raises a question of records. Most of the records are kept by the Welfare Department for each client. This causes a communication breakdown.

The Rutherford County Department of Public Welfare stated that their most desperate problems are referred immediately and others are screened out because of the overload on the Vocational counselor. The Department of Public Welfare does not have any knowledge of the criteria of Vocational Rehabilitation for establishing a client's eligibility. This department states that Vocational Rehabilitation always has at least an initial interview.

Mr. Morrow stated that some people are too disabled for Vocational Rehabilitation, and this is the reason for rejection.

At the Rutherford County Department of Public Welfare, the caseworkers have talked with Vocational Rehabilitation about clients in regard to personality. The motivation of some clients was discussed as being a determining factor as to whether or not this client was a success. Vocational Rehabilitation can aid to a certain extent, but the client must take a certain amount of responsibility. Recently clients have been turned down due to the lack of funds in Vocational Rehabilitation.

Mr. Avery stated that there is a need for awareness of understanding between the two agencies. There also seems to be a lack of awareness on the public's part.

The Rutherford County Department of Public Welfare has found that other people in the community, such as the family physicians, act as referring agencies. The Vocational Rehabilitation resources are not known by the Department of Public Welfare. The caseworker refers the client to Vocational Rehabilitation to find out what resources are available. The biggest difficulty is follow-up.

Rutherford County Department of Public Welfare also stated that there is a need for job training geared to the opportunities in our area. VR's job training should be broadened. There have been successful clients referred to VR because of the resources of medical attention and job training.

A case example was presented at this time by the Rutherford County Department of Public Welfare. This client had a bad heart condition. VR financed the heart operations that were required, gave basic education, and specific job training. This client is now employed in a successful job. However, this man was intelligent and ambitious; therefore, he was easy to work with. A lengthy waiting period was involved and the client was forced to be a "bit pushy."

McDowell County Department of Public Welfare questioned whether or not there is adequate information as to the person with whom VR is working. Would a possible referral agency for psychological testing and more extensive counseling serve any purpose? Would this keep VR from turning away those that are non-motivated? There is a need for a diagnosis of each client, counseling, and channeling in the right direction.

Mr. Morrow suggested that the VR counselor spend more days in Rutherford County for the VR counselor to see new clients and follow-ups. The Department of Public Welfare stated that this would help a great deal.

The question was raised as to whether or not there were other services other than money within the VR agency.

The Rutherford County Department of Public Welfare introduced recipients of VR services: Mr. Norville and Mr. Hardin, businessmen in Rutherford County.

Mr. Norville was trained in bookkeeping and accounting after contact with Vocational Rehabilitation. It was many months before he could obtain a job. VR worked with him until he found a job, which was managing a grocery store that VR bought for him.

Mr. Hardin suggested that each client be analyzed to make sure the client will go all the way and no money will be wasted.

The Rutherford County Department of Public Welfare brought up the fact that when the clients get a job and are able to support themselves, there seems to be no resources for other expenses such as medical and hospitalization.

Dr. Brooke Johnson from the New River Mental Health Center stated that before he had a VR counselor on his staff, a counselor from Broughton Hospital visited the center on a regular basis. There is a new program being developed with a supervisor at Broughton Hospital and a VR representative distributed in the different counties.

There is a need for more cooperation between all agencies. Not all patients are as aggressive as we would like them to be.

The New River Mental Health Center VR counselor is included in their staff conference about patients. This is where some of VR's cases are obtained. The counselor has access to all patient records. Any dictation he has regarding this client is dictated in chronological order into the patient's chart. He does keep his own records.

The question was raised by Dr. Williams, director of the Rutherford Mental Health Center, as to permission of records release to outside VR counselors.

Mr. Morrow stated that there is a need for proper records to be kept in order for proper follow-up to take place.

Mrs. Eply from the Cleveland County Mental Health Center stated that they have a problem of communication. A letter of referral from their center is written, but then no contact is made with the client. This is possibly due to the lack of funds, but nothing is sent to the patient stating that contact will eventually be made.

There is a need for a more local office.

Mr. Avery stated that Broughton Hospital hopes to get VR representatives in the different counties.

Cleveland County Mental Health Center would like to know what does happen to their referrals?

Mr. Dunson from the N. C. Study in Vocational Rehabilitation brought up Senator Kennedy's statement that follow-up is very important. Sometimes too many agencies are working with the same people. There is too much overlapping involved.

Dr. Williams from the Rutherford Mental Health Center gave several suggestions for follow-up: 1) On the initial contact with an agency, one staff member takes the responsibility for seeing that when referred to another agency, the referral is carried out. This process is known as "hand-leading." 2) A paid employee is hired to aid in follow-ups. This determines how a patient flows through the helping network. 3) There is the problem of how to get into the network. There is the need for a sense of responsibility on the agency for transfer of a patient, so that the patient does not drop through the crack. Once a patient gets into the agency, it is the agency's responsibility to see that referral is carried out.

Mr. Morrow questioned if we have not failed ourselves when referring agency does not get back follow-up or patient is not helped at all.

Mr. Fred Street from the Technical Action Panel stated that he had encountered the same basic problems: lack of personnel, communication, and money.

Miss Wilkie from the Department of Education stated that they now have a VR counselor in their Special Education program. Mr. Hughes works with the mentally retarded, the physically handicapped, and the drop-outs. He is now in the process of obtaining scholarships for college for the physically handicapped. He is working in the age range of 16 through 20. Referrals are made through school faculty. This has been accepted well by the parents, at least no problems have arisen. There have been a few who have been referred by other than school faculty members.

Kings Mountain School System states that there is a need for a VR program within their system. They have a special education program. They are questioning how to go about obtaining a VR counselor for the schools.

The problem of disturbed children and what there is to be done for them was discussed. Broughton Hospital takes a few children and Butner Hospital has a capacity for about 30.

G. Martin Amacher
Chairman

**ADDITIONAL COMMENTS FROM PANEL MEMBERS
IN REFERENCE TO PUBLIC HEARING
HELD AT RUTHERFORDTON ON APRIL 10, 1968**

I have attempted to formulate in brief what appeared to be the central concerns and issues raised at the public hearing in Rutherfordton on April 10, 1968. In reviewing the minutes of the meeting, it appears that the central concerns raised were the lack of communication between agencies and the resulting lack of continuity of care for clientele.

There appeared to be many factors that have contributed to the lack of communication between agencies. One big factor appeared to be the demand made on Vocational Rehabilitation and its shortage of manpower to meet this demand. Along with this shortage of manpower appeared to be the problem of the absence of a local Vocational Rehabilitation representative in some counties and the difficulties that are encountered from Vocational Rehabilitation being administered on a regional basis. Therefore, in many counties, Vocational Rehabilitation has no local agency identity which results in the public's not being informed of the available services. This also contributes to other agencies not being adequately informed of the services through VR and the criteria for eligibility for services. This was substantiated by representatives of the Department of Public Welfare and also the public school system. Department of Public Welfare representatives noted that they sometimes referred clientele to Vocational Rehabilitation to determine eligibility and, therefore, subjecting a client to confusion and unnecessary rejection. The public school representatives who were there indicated that they became aware of the possibility of VR assistance in special education, not through a general awareness of the Vocational Rehabilitation program on a state and local level, but through word-of-mouth from another school system.

Most of the agencies represented indicated that there is poor referral communication between all service agencies. This was especially documented by the fact that representatives from two agencies had been working on the same case, but apparently had not communicated with each other. From what was reported at the hearing, one agency had made numerous inquiries about getting a child hospitalized; and it was later revealed by the other agency representative that this child was under their care and management, but apparently there had been no communication between the two agencies. Several agency representatives brought out the concern that clientele are frequently lost in the referral process from one agency to another. The referring agency frequently gets no feedback of what happened to the referred child.

The two former VR clients who made appearance at the hearing seemed to represent a good contrast in how clientele do receive services from VR. One of the former VR clients apparently had been quite aggressive in his contact with Vocational Rehabilitation and implied that it was only through his persistent initiative that he did receive services from VR. From what was produced at the hearing, it appeared that the other Vocational Rehabilitation client has not taken this much initiative with VR, but apparently had been carried through the process by the Department of Public Welfare while working intermittently with VR. Both of these former VR clients mentioned several times that watchmaking had been suggested to them for vocational training, while there was no particular resource for employment in their locality for this particular skill. The former VR client who had been persistent with Vocational Rehabilitation in applying for their services made it appear that VR would not have necessarily followed through with his application unless he had repeatedly "hounded" them. This could suggest that unless clientele do not possess and display a great deal of motivation they may frequently cancel themselves out. The one former Vocational Rehabilitation client who had been successful in his application through his persistence indicated that he may have had multiple concerns

other than his tangible handicap and that he could have utilized the services of an agency that conceptualized the total life situation of the client, in addition to his chief and initial reason for application.

It was my impression that factors that were implicit in the issues raised at the hearing were that if VR cannot establish a local agency identity in each county, thereby creating an awareness with the lay and professional community of its services, what is the rationale for a Vocational Rehabilitation program being administered separately from other agencies, such as Departments of Public Welfare or Mental Health Centers? Could Vocational Rehabilitation services be more effective and reach a large number of potentially employable persons if it were a unit, or administered under the umbrella of a comprehensive care agency? An example was given at the hearing of how some VR services are provided in one area through a comprehensive mental health center.

I think an implicit issue that was present throughout this hearing as voiced by former VR clientele and other agencies is that VR should acquire more of an orientation in the social and behavioral sciences. Such an orientation and concept by VR seems necessary for the sustained rehabilitation of clientele and if VR is to be an integral part of a community network of services.

G. Martin Amacher

**ADDITIONAL COMMENTS FROM PANEL MEMBERS
IN REFERENCE TO PUBLIC HEARING
HELD AT RUTHERFORDTON ON APRIL 10, 1968**

The most dominant, recurring theme in the testimony before the committee was that there was inadequate coverage of the area around Rutherfordton by vocational rehabilitation counselors assigned to service that area. Not only was the area inadequately covered as to the number of vocational rehabilitation counselors but the assigned counselors to the area, who appear to be coming for one or two days per month, changed frequently, and that when a counselor was in the area that the volume of referred clients was so great that the counselor had need to ration his time to a mere fifteen-minute interview.

A number of the people to testify before us indicated that while referrals were always graciously received by the vocational rehabilitation counselor, the referring agency was rarely informed as to the disposition of the referral unless the referring agency had need to follow up and try to find out what happened to the prospective client.

It became evident to the panel that one of the outstanding needs in the area is for the vocational rehabilitation people to be able to extend rehabilitation services to cases now deemed "non-feasible." The testimony offered by the representative of the McDowell County Department of Public Welfare and that offered by the Rutherford County Department of Public Welfare did not contradict, but rather strengthened each other's.

Mr. Trevor Williams had arranged to have two successfully rehabilitated citizens to come before us and submit to questioning by the panel. Two clients who had been under the sponsorship of the Department of Public Welfare of Rutherford County testified regarding the treatment they received from the vocational rehabilitation department. One of these gentlemen had been referred to the vocational rehabilitation department by his local physician and the first interview of this man with a vocational rehabilitation counselor proved ineffective because of the refusal of the prospective client to accept the treatment recommended and offered by the rehabilitation counselor.

Apparently, the referring physician had an excellent grasp of the depth of services being offered by vocational rehabilitation so he again referred his patient to vocational rehabilitation. The testifying citizen stated that the second vocational rehabilitation counselor took into consideration his personal desires and together they worked out a plan for his rehabilitation. It involved expensive medical treatment and surgery followed by a course of training to bring his educational level up to an eighth grade standard so that he could attend barber school. Cooperation between the welfare department and the vocational rehabilitation counselor has resulted in long and torturous rehabilitation of this man by providing him with sufficient education and technical training to enable him to be self-supporting.

The other citizen who testified indicated that his vocational rehabilitation counselor had provided training in operation of an IBM punch card machine, but that he was unable to find employment as a male in an area preponderantly female in actual practice. He stated that his vocational rehabilitation training had also embraced a basic accounting course and the vocational rehabilitation continued to assist him until he had been established in his own small neighborhood grocery store operation. He expressed confidence in his ability to continue the operation of the grocery store and felt that he could continue to be self-supporting because of his rehabilitation training and the assistance given to him by the vocational rehabilitation. This man's living had been furnished during his training by the Department of Welfare who had referred him to vocational rehabilitation.

Both of the above clients had been victims of rheumatic heart ailment all of their lives and both of them exhibited gratitude for services rendered by vocational rehabilitation.

In the afternoon the panel had before them an extremely able period of testimony involving the Cleveland County Mental Health Center, the Cleveland County Mental Health Clinic, the Technical Action Panel, and a representative of the secondary county schools of Rutherford County. Once again as in the morning session, we heard recurring complaints that there were too many changes in the counselors assigned to the area and that while all of the vocational rehabilitation counselors appeared to be courteous and willing, their volume of referrals was so great that there was no follow-up on most of them and that frequently nothing at all was done. The turnover in the assigned vocational rehabilitation counselors frequently resulted in the loss of all records kept, in that they were not available to the succeeding vocational rehabilitation counselor. It was made to appear to this panel member that stabilization of vocational rehabilitation counselors is vital to the future success and growth of the program and that it would be mandatory that a proper procedure be worked out for the transfer of case records from counselor to counselor so that this matter of "starting over" would be reduced to a minimum.

The fact was brought out that the personnel assigned to the handling of prospective clients who were referred by the mental health people were frequently wholly inexperienced in handling mental patients who were candidates for rehabilitation. Once again it was brought out that the referring agency was not kept informed as to the disposition of the referral.

A representative of the secondary county schools of Rutherford County appeared and gave heartening testimony as to the good work being done by the vocational rehabilitation counselor assigned to work with applicants sixteen years of age and up in the four special education classes in the Rutherford County High School system. The testifying witness indicated that the counselor was available to the teachers upon request and to the students themselves upon request to offer counseling and guidance and possible placement to be effective when schooling ended. It appears that the special education classes were being operated by the school under an enabling act of the legislature which provides trained personnel and additional teacher-student ratio for handicapped children who require increased attention.

A representative of the Kings Mountain City Schools was present to try to learn how this school system might go about installing the same kind of program.

General impressions gleaned from the four hours of testimony indicated that the:

- Item 1—Services available to the area around Rutherfordton were not widely known to the public or even to agencies who might be expected to make the bulk of referrals.
- Item 2—The area is woefully understaffed by vocational rehabilitation counselors as related to potential need for rehabilitation services.
- Item 3—A proper avenue should be created for an exchange of information between vocational rehabilitation and referring agencies to insure that each will know what the other is doing.
- Item 4—Increased participation by rehabilitated clients ought to be sought in future hearings of this kind.

C. K. Avery

**ADDITIONAL COMMENTS FROM PANEL MEMBERS
IN REFERENCE TO PUBLIC HEARING
HELD AT RUTHERFORDTON ON APRIL 10, 1968**

Dr. Williams did an excellent job of organizing the meeting and getting participation of local community agencies. Representatives of the Department of Public Welfare, Department of Public Health, Mental Health Centers, and Technical Action Panel and Department of Education participated in the program.

The highlight of the meeting, in my opinion, was the appearance of two recipients of Vocational Rehabilitation services. It would seem from their testimony that motivation does play a part in determining eligibility, and a highly motivated recipient can expect to receive services. It does raise the question of what happens to the client who is not so highly motivated or educated. Also, one wonders exactly what is the criteria used to determine if a person is feasible for VR services. The meeting also reinforced the fact that there is generally lack of knowledge of what services are available to persons in the community, not only for Vocational Rehabilitation services, but for other services as well.

Mrs. Carolyn Dunagan and Mr. Ed Garrison from the Rutherford County and McDowell County Departments of Public Welfare, told of a large turnover in Vocational Rehabilitation counselors and heavy caseloads carried by the counselors, and lack of time to discuss their cases with the social worker. They expressed concern about duplication of services and felt that job training should be more in line with job opportunities in a certain locality. Mrs. Epley, social worker with the Gaston County Mental Health Clinic, felt the need for more follow-up information on referrals to Vocational Rehabilitation counselors.

Dr. Brooke Johnson, Clinic Coordinator, New River Mental Health Clinic, gave an interesting summary of his agency's benefits of having a Vocational Rehabilitation counselor assigned to his agency. Dr. Johnson pointed out how information was shared in his agency, and how the Vocational Rehabilitation counselor worked as part of the Clinic team.

Mrs. Aileen Hamrick, social worker, Rutherford County Mental Health Clinic, made an informative presentation, pointing out that in their area Vocational Rehabilitation acted as the guest agency. The suggestion was made on how it would be for Mental Health, Public Welfare and Public Health personnel to be assigned to Vocational Rehabilitation offices.

In the afternoon session, Mr. Fred Street of the Technical Action Panel discussed his program on informing people of services available to them, and how he referred clients to Vocational Rehabilitation.

Miss Amelia Wilkey, Supervisor, Special Education, Rutherford County School System, told us about the Vocational Rehabilitation counselor assigned to the Special Education Program. Apparently, this program has been very successful and the Vocational Rehabilitation counselor works very closely with the teachers. Several school administrators from the Kings Mountain School System were present, as they were interested in starting a similar program in their school system. It was pointed out that there was a continuing need for services to children, and it was felt that more services in residential care was needed.

In summary, I would say that the success of our public hearing in Rutherfordton was due to the highly successful ground work performed by Dr. Williams and his staff. The community's interest in establishing new and expanded innovated VR programs was evident and gratifying. I was honored to serve on the panel, and hope that my observations will be of service to you.

Robert M. McDaniel, Jr.
Chairman

**REPORT OF
MENTAL HEALTH—MENTAL RETARDATION—CEREBRAL PALSY TASK FORCE
OF THE
MOUNTAIN REGIONAL ADVISORY COMMITTEE
NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION**

The early work of the sub-committee involved identification of major problems where improvements would be very beneficial.

First, education is considered of primary importance if early recognition of problems of clients is to be accomplished. For example, early placement in special education classes before a child compounds his problems with repeated failures is very desirable. Education should focus on professionals in the community, and at the same time, on the general public.

Second, the committee felt that several communication problems could be improved upon. Contact with potential clients can be a communication problem. Adequate communication with the general public is very desirable, especially if we expect to get sufficient interest and support across the state for the necessary programs to carry out our goals. VR should be considered an interagency group having free communications with all agencies. One way this has been accomplished in one community has been to form an interagency council in which various agencies keep each other informed about what the other agencies are doing. VR would be a logical participant in this kind of organization. Proper communication with employers is necessary for the success of a job placement program.

Third, identification of clients (or case finding) is an area where innovative ideas are needed so that potential clients and parents of potential clients would be informed of the services available so that they might make their needs known to VR.

Fourth, transportation is a problem in many areas of our state and even though a handicapped person may be identified, informed, and directed to the proper agency, he may not be able to get there.

Fifth, employment or activities which represent the client's maximum potential is, of course, the goal. The committee felt that if the previously mentioned areas could be improved upon, this fifth problem would be considerably resolved.

The problem of *how* to make improvements in these areas became the committee's main concern. Further discussions dealt primarily with VR procedures, what was wrong with VR offices and, in general, what should be done by VR to improve VR services. Later, however, we realized that it might be beneficial to consider how other agencies could make plans to work more effectively with VR and not expect VR to be working as an outside agency. Community agencies and professional people should invite VR personnel to be a part of the various programs that are going on in the communities. In this way, VR would be looked upon as another community resource, VR would begin to see more of the communities' problems, and would then be more able to help solve these problems in the most effective way possible. The State VR Agency has already begun work in several community mental health programs in the State. The VR counselors in these programs have a joint responsibility to the agency with which they are working as well as to VR. He becomes more involved with the patient as a total person, and becomes more aware of the patient's needs and in this way is able to be concerned about the overall rehabilitation of the client.

It is easy to see how the VR personnel could do a better job much more easily with the above mentioned problem areas if he could be more involved and knowledgeable about the communities' needs

and assets. In education of professionals and general public, for example, if the VR counselor could feel more a part of the community in which he is working, the increased personal contact with community agencies and general public would cause education to be more automatic. While this would depend largely on the philosophy of the primary agency with whom the VR counselor would be attached, one would hope that all agencies would see the need for better communications with other agencies in the community, and VR could become a facilitator of such communication in a community. Contact with potential clients, then, would not be just the responsibility of the VR counselor, but the responsibility of all the community agencies. The general public would become more aware of VR services because VR would be one part of several community agencies so that whenever any of these agencies informed the public about its' program, VR would be included.

One of the most salient points that the sub-committee realized is the tendency for agencies to work in isolation from other agencies. One way to begin a co-ordination of community agency functions for the benefit of the people they are serving would be to employ personnel jointly among various agencies of a community. VR could very easily have a counselor employed jointly by welfare, health, mental health, school, and possibly other agencies in a community. Not only would VR have a better communication with the community agencies, but would then be in a position to become the facilitator of better communications between agencies in the community.

Brooke R. Johnson, Ph.D., Chairman
Mrs. Allen S. Johnson, Jr.
Mr. DeWitt Trivette
Mr. Bill West
Dr. Trevor Williams
Mrs. David L. Pressley
Mr. Thomas W. Lane

**REPORT OF
ALCOHOLIC TASK FORCE
OF THE
MOUNTAIN REGIONAL ADVISORY COMMITTEE
NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION**

The Alcoholic Task Force of the Mountain Regional Advisory Committee on Vocational Rehabilitation submits to the committee a summary of its work in the following manner: An individual interpretation by each member of the task force, and a combined summary statement from the chairman.

I. Interagency Cooperation

The communication gap exists between people-centered-service agencies. This is true of whatever service offered by any agency and another agency working with the same client. It would add nothing to the report to enlarge this statement other than to say that the Alcoholic Task Force of the Mountain Regional Committee is in agreement that the gap must be closed if effective service is to be given in any area of client need.

Cooperation in service will greatly improve effectiveness of any remedial effort. Certain specialties and specialists will improve when areas of prime concern do not serve to overemphasize responsibility thus causing misunderstanding.

II. Improved and Intensive Educational Effort

The Alcoholic as a client of vocational rehabilitation needs an understanding of the program of vocational rehabilitation. Educating the sick will require instruction from many sources:

1. State hospitals are engaged in vocational programs that last for the length of patient confinement.
2. An earnest effort is being made to encourage the trainable alcoholic to try vocational rehabilitation as a means of cure.
3. Schools, Alcoholic Centers, and any other alcoholic problem-solving agency will have to enter an even more intensive program of educating the alcoholic about the advantages of the vocational rehabilitation program.
4. Vocational rehabilitation can help by increasing number of counselor staff, both professional and volunteer.
5. Adequate information about success of program to the people responsible for allocating funds, that these people may know the value of the time and money spent is not wasted; furthermore, that vocational rehabilitation needs large enough appropriations to be workable.

III. Result of Research

Result of work with patients of Broughton Hospital

- A. The number of patients interviewed is inadequate to build a true profile.
- B. Only a few patients had knowledge of vocational rehabilitation.

- C. Only a few patients actually had been served by vocational rehabilitation.
- D. Only a few patients actually were in need of vocational rehabilitation.
- E. Most of the patients had had satisfactory work experience which they intended to continue.

IV. Recommendation

- A. A more comprehensive research program working for a longer time with enough patients to be able to better determine the identifiable type of potential vocational rehabilitation client from among the alcoholically sick.
- B. A group of interested but objective people to be constituted into this continuing research team; even to the extent of permanency.
- C. The findings of such a committee, kept current, to be shared with all agencies that serve the alcoholic in any capacity.

Mr. John M. Pollack, Chairman

**REPORT OF
VISION TASK FORCE
OF THE
MOUNTAIN REGIONAL ADVISORY COMMITTEE
NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION**

The North Carolina State Commission for the Blind aided by the North Carolina Association for the Blind and local Lions clubs offer a comprehensive service program to blind and visually impaired persons in North Carolina. Because of limited funds, the North Carolina Association for the Blind and local Lions clubs only provide those services to the blind and visually impaired of North Carolina when Federal and State regulations will not permit the North Carolina State Commission for the Blind to do so. Even though the service programs of these public and private organizations are tremendous in scope, there are certain areas in which services need to be extended, improved, and developed. Those individuals who even though are determined rehabilitated oftentimes encounter difficulty, in securing the recommended eye medications to conserve their vision. For example, a glaucoma patient in most cases will need to use eye medication the remainder of his life. If this individual only earns \$50 or \$60 per week and has a family to support, his glaucoma medication, which could conceivably cost him \$20 to \$30 per month, would be extremely difficult for him to manage. Federal and State funds should be appropriated to some social or health agency to sponsor the purchase of eye medications indefinitely for those individuals who are determined not able to purchase the medications themselves.

Because there are approximately 12,000 legally blind persons in North Carolina, the Sheltered Workshop system for the Blind in this State should gear its overall program to employing as many of these unemployed individuals who are potentially productive, marginal producers and submarginal producers as possible. The Sheltered Workshops for the Blind of North Carolina, which are autonomous organizations, and the Commission for the Blind should develop work activity areas in each of the Shops in order to employ the marginal and sub-marginal producers. The Durham Workshop for the Blind has embarked upon a program such as this and the Commission for the Blind is encouraging the remainder of the Shops to follow suit. At the present time almost all of the Sheltered Workshops for the Blind are concerned with the employment of highly productive visually impaired persons. More emphasis should be placed regarding the placement of productive blind and visually handicapped persons in industry. In order to do this additional rehabilitation field personnel would be needed to concentrate heavily in this area. Also, Federal and State funds should be appropriated to move a client and his family from one location to another in order to accept gainful employment.

A more specialized approach should be taken in the rehabilitation of the deaf-blind. A rehabilitation facility (workshop and training facilities) especially adapted to the vocational needs of the deaf-blind of employable age is needed.

The Rehabilitation Division of the North Carolina State Commission for the Blind should become more involved with labor unions and management so that they may be informed concerning the abilities of the blind and visually impaired. Additional rehabilitation counseling positions should be authorized for the Commission in order to divide large territories, which range from six counties to twenty counties per district with one caseload counselor working in each district, so as to more efficiently serve the rehabilitation needs of the visually handicapped. Also, we should think in terms of broadening the definition of vocational rehabilitation to include the independent living concept. Through rehabilita-

tion services, an individual might be afforded the ability to care for his daily needs, but not engage in gainful activity. In many cases, there are no Federal, State, or local funds in order to provide services to the needy unless they meet present eligibility and feasibility requirements for vocational rehabilitation services. Those who do not meet the requirements to be served through vocational rehabilitation and who cannot finance the needed services for themselves should be given rehabilitation services. The Medical Division of the North Carolina State Commission for the Blind sponsors eye surgery and/or treatment for the indigent irregardless of work potential, but in cases where the adult indigent need other types of surgery or treatment there are no Federal or State funds for this purpose.

In conclusion, all agencies serving the disabled population should disseminate information regarding their programs to the general public and to all other organizations and agencies which are concerned with the welfare of the citizenry of this State.

Jesse I. Sherrill
Chairman

**REPORT OF
MANPOWER, TRAINING, EVALUATION, COMMUNICATIONS AND
PUBLIC RELATIONS TASK FORCE
OF THE
MOUNTAIN REGIONAL ADVISORY COMMITTEE
NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION**

The Manpower, Training, Evaluation, Communications, and Public Relations Task Force met September 20, 1968 at Western Carolina Center. Present were Mr. G. Martin Amacher, Dr. Joseph H. Wishon, and Dr. James C. White.

The role of the Task Force was discussed. It was decided that the Task Force was commissioned to respond to the problem areas reflected in the Task Force title and make specific recommendations regarding approaches to alleviating manpower shortages, training demands, evaluation, and rehabilitation efforts and manpower training, and communicate with other agencies; and finally, to improve public education regarding the role of vocational rehabilitation.

The Task Force members felt that innovative approaches regarding training, manpower utilization, and joint agency programming will be required. Traditional methods of recruiting, utilizing and training of personnel will probably not generate significant advances toward problem solutions; and deficiency lags will continue as vocational rehabilitation expands services to a broader population.

Three main recommendations were formalized at the Task Force meeting:

1. It is recommended that, rather than trying to just recruit and increase the numbers of vocational rehabilitation counselors, the vocational rehabilitation counselor be more thoroughly trained and utilized as a coordinator of counseling services, delegating many of his present duties to counselor technicians. The Task Force recommended that the Vocational Rehabilitation Counselor, because of his increased training, benefit from a more professional identity. Universities, colleges, and area training institutions could examine the possibility of training specialists in this area, as well as develop programs for ancillary personnel.
2. The counselor technician could be trained in community colleges and participating agencies as counselor aides. Rehabilitation services often exist in a variety of institutions. Each of these institutions could participate in the counselor technician training, and the utilization of these individuals could be coordinated by the more sophisticated vocational rehabilitation counselor.

Joint utilization of personnel involves the third recommendation.

3. Community agencies should consider cooperative rehabilitation programs jointly planned with the vocational rehabilitation agency. It is recommended that cooperative programs would relieve to some degree the acuteness of the manpower shortage; and overlapping involvement would increase communications and public relations and provide a good environment for program evaluation. Joint rehabilitation programming would also provide an excellent climate for some type of internship program or on-the-job training for counselors, technicians, or aides.

The Task Force felt that more efficient and complete utilization of the vocational rehabilitation personnel, as well as related personnel in participating agencies, should be developed as a first priority.

Responding specifically to the problem of public relations, the Task Force members recommend that vocational rehabilitation needs to reach the consumer, as well as the people or agencies who finance or support vocational rehabilitation. Increased advertising of services is recommended. There seems to be a need to motivate the consumer to seek vocational rehabilitation assistance and also to motivate agencies to refer clients to vocational rehabilitation. Presently, many agencies overlap in their service functions. The Task Force members felt that, for example, many of the services presently defined as health, social welfare, or other forms of assistance overlap with rehabilitation goals; and consequently, the patient needs to be referred freely by the agencies as resolution of his problem is attempted.

G. Martin Amacher
James C. White, Jr.
Co-Chairman

**REPORT OF
REHABILITATION WORKSHOPS AND FACILITIES
OF THE
MOUNTAIN REGIONAL ADVISORY COMMITTEE
NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION**

1. Mr. Robert Gibbs resigned as Chairman of the Task Force, effective March 27, 1968. Mrs. Sarah H. Bray accepted the chairmanship and proposed that Harry Ingram and Thomas Boring be added to the Workshop Task Force, and that they be duly notified.
2. The recommendation had been made in March that the State Workshop movement employ a co-ordinator to work with all workshops of the State. Upon investigating, we found that this grant was only available with application from one individual workshop, not as a State association.
3. To clarify Mr. Howard Earp's position and duties with DVR, the committee decided to investigate to be sure that he would not be able to help in some ways with the duties to be assigned to the co-ordinator, even though they felt that his position would not enable him to aid this program.
4. Suggestion for effort is being made to set up programs for the training of workshop personnel possibly through community colleges. More information is needed concerning the present process of making policies within the workshops on salaries, raises, insurance, vacation, sick leave, and pension policies. Now we have workshop guidelines and it is thought that the greater portion of this is covered except for insurance. The State Association asked Chris Heracklis to research the insurance situation. Mrs. Bray suggested that we needed to dive further into the area of pension plans since only the state facility workshops were covered. Most Board of Directors are most interested possibly because they don't have the fund necessary for a plan of this type. The State Workshop Association meeting was held on October 25, 1968; and the Association reviewed the policies of two insurance companies and delayed this final decision for thirty additional days.
5. The suggestion was made that each workshop investigate the service of PACE students for the summer months, and we also should look into the health carriers also for the Man Power Program.
6. The committee heartily recommended the whole idea of having regional facilities such as Woodrow Wilson, since too many clients are having to go to Virginia. There is a possibility that the VA Hospital at Cullowhee would be a good facility. It is being vacated and this should be investigated. We are developing recommendations that this would be a possibility and if you could get the information together on this situation, we could present this as a possibility for a suggested site. While we are talking about the need for a center, one other area we are lacking is a half-way house which we need very much. We encourage half-way houses for the workshops in scarcely populated areas that could not supply sufficient students without housing.
7. Woodrow Wilson was begun in an old VA facility and look where it is now. We got all of Butner for \$1. Another possibility is that the VA Administration makes it possible for civilians to utilize special facilities that might be available in the VA facility. We might find that the VA would offer direct facilities and resources needed. A large area is needed to have a comprehensive rehabilita-

tion center. A center without a sizeable amount of land and large enough number of vocational training and technical and trade-training programs is useless because many patients must have treatment and training moving along simultaneously. Wouldn't it be ideal to locate right near a pool of professional people such as would be found near a VA facility. VA certainly has these qualified people. Professional and qualified people and equipment are the hardest part of opening a facility of this type. We need to check into the situation with the Orthopedic Hospital in Asheville. They want to build a rehabilitation center, but it would be foolish to start building when only about fifteen to twenty miles away they could obtain completed buildings.

Suggestions for immediate considerations:

1. Lack of communication between agencies still heads the priority list.
2. A breakdown into four areas of the state workshops with the directors meeting being held at a convenient time for the President, Tom Boring, or President Pro-Tem, Sarah Bray to be able to attend such meetings to benefit our study into programs involving local problems rather than situations involving the full state.
3. Department of Vocational Rehabilitation area meetings to include workshop directors from the area to present and/or discuss the training in areas involving workshops, being certain the DVR and workshop counselor understand the programs in the workshop area.
4. Inservice training for workshop staff and workshop directors is in immediate need in our state of North Carolina.

Sarah Bray, Chairman

**REPORT OF
ARCHITECTURAL BARRIERS TASK FORCE
OF THE
MOUNTAIN REGIONAL ADVISORY COMMITTEE
NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION**

The Committee on Architectural Barriers submit that the enormous cost to the public of making special provisions for handicapped persons could be greatly reduced by careful planning of buildings and seeing that public and semi-public buildings were accessible to handicapped persons. This reduces the dependence of the handicapped and gives them an ability to look after themselves at a much reduced cost.

Publicity in this direction is needed. Some accomplishments can be recorded. The North Carolina Building Code beginning with December, 1967 requires that all public buildings constructed after July 1968 will be specifically constructed so as to be available to handicapped persons.

In other States public rest stops along Federal Highways have been improved to the extent that they are available to persons in wheel chairs, but in North Carolina this has not been the case.

Specifically, your committee recommends that existing public buildings should be converted as rapidly as possible to make them accessible to persons who are handicapped and in wheel chairs and, particularly, as other alterations are needed in these buildings. For instance, many of our court houses which are not open to the handicapped could be made so in connection with converting to the District Court System if the matter were called to the attention of Superior Court Judges of North Carolina who are in charge of making the transitions.

With respect to private enterprise with facilities for the public, the town of Mocksville has successfully made all of its buildings open to the handicapped and the Thru-Way Shopping Center, the Coliseum in Winston Salem, and the new Wachovia Bank Building there are outstanding examples of instances in which private enterprise has opened its doors in this respect. The handicapped themselves through the North Carolina Paraplegic Association, Inc., have carried on a long-time campaign in this regard, but the force of the Vocational Rehabilitation Advisory Committee can certainly well be added to their efforts in this regard to open as many doors as possible.

The increasing cost of individual servants will make it a practical impossibility for handicapped persons to live alone and be independent unless progress is made in this direction, and we would strongly urge that high on the list of recommendations would be an aggressive campaign by the Vocational Rehabilitation Advisory Committee to urge the merit and advantages of such provisions on each person connected with the building, architectural and construction professions, as well as individual owners. It is, of course, essential that the plans be developed along these lines and that such persons be contacted at a very early stage in planning in order to make the necessary arrangements at the least possible cost.

Josephine Cooley, Chairman

REPORT OF THE PIEDMONT REGIONAL CITIZEN'S ADVISORY COMMITTEE OF THE NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION

INTRODUCTION

This report of the Piedmont Regional Citizen's Advisory Committee is submitted to the North Carolina Study in Vocational Rehabilitation to reveal its areas of concern, problems it has observed and gaps uncovered in Vocational Rehabilitation Services to the people of the Piedmont Region of North Carolina. The report also contains those recommendations that the committee felt were necessary and relative to their findings.

There was an attempt made in writing this report to make it succinct, with the least amount of verbiage possible, in the hopes that it can be easily and quickly read by busy, professional and administrative persons. However, we hope that sufficient information and comment are given about the problems and recommendations in order for a person reading the report to understand the problem and the thinking of the committee in making a recommendation.

In beginning the investigation of Vocational Rehabilitation Services for the Piedmont Region of North Carolina, it was decided that public hearings would provide us with the most realistic view of what is actually taking place in Vocational Rehabilitation Programs, what the problems are in carrying out these programs, where a paucity of services exists and some recommendations as to methods of dealing with the problems and the lacunae.

Since the major population in the Piedmont Region resides in metropolitan areas and the other Regional Advisory Committees were holding public hearings in less populated areas, it was decided that the Piedmont Advisory Committee's Public Hearings would be held in two large cities, Durham and Charlotte.

The participation of agencies and citizens in these hearings was excellent. The material was presented in a realistic and frank manner. Members of the Piedmont Regional Advisory Committee who sat on the public hearing panels probed deeply and expertly into the problems that were presented and helped the participants to formulate those solutions, ideas and recommendations they held about the existent and needed programs in Vocational Rehabilitation.

Although the largest portion of this report came directly from the public hearings, a number of problems and gaps in rehabilitation services were pointed out and discussed in regular advisory committee meetings which are included along with the recommendations they illicit.

I. The Character of Vocational Rehabilitation

A. Problems:

1. In the first meeting of the Piedmont Regional Advisory Committee, a major issue arose which was discussed in the ensuing meetings of this committee. This issue concerned the boundaries of services to be observed by Vocational Rehabilitation Agencies. Some members of the committee felt that the term vocational should be dropped

leaving the title of the agency, The North Carolina Division of Rehabilitation. Other members of the board felt the adjective vocational should remain and further the services offered and to whom they are offered should be concretized so that definite boundaries would be established. These members felt that if this were done, it would help other agencies and citizens to know what to expect of the Vocational Rehabilitation Agencies, would aid the personnel of Vocational Rehabilitation to know its functional limits and expedite the development of plans and priorities.

The group who wished to drop the term vocational felt the need for a general rehabilitation agency which would provide rehabilitation services for all elements of of the population whether the rehabilitation needs were vocational or not.

2. It was unanimously felt by the advisory committee that the position of Vocational Rehabilitation as a division of the Department of Public Instruction was debilitating to the Agency. This position restricts adequate and realistic budget and program development. It dilutes the political status of the agency when it encounters legislative problems and action. Also, this weak political status prevents the Division's development of an image other than that of a step-child to a super governmental department and hinders planning for community services and cooperative programs.
3. There is a major difficulty in coordinating rehabilitation services in cities, counties and communities. The difficulty in aligning services for Vocational Rehabilitation clients absorbs a great deal of the Vocational Rehabilitation Counselor's time reducing to a great extent time allotted for client-counselor contact. In addition, the lack of coordination in the communities creates duplication and overlapping of services.
4. It was found that there existed an inconsistency in the quality of services, the Division of Vocational Rehabilitation purchased from vendors, facilities, workshops agencies in the Piedmont Region. In In some instances the services purchased were inadequate and may not have resembled the service expected when the client was referred.
5. It was found in the larger cities of the Piedmont Region that there was an exceptionally high turnover of Vocational Rehabilitation personnel. This created a number of difficulties in program development and working relationships with other agencies and groups.
6. In 1967 there were 9000 referrals to the Division of Vocational Rehabilitation which were closed as rehabilitated, while in the same year there were 6000 referrals that were closed as not feasible for rehabilitation services. Six thousand referrals found not feasible for rehabilitation services seems to be an exceptionally high number. The committee felt that there must be a misunderstanding of Vocational Rehabilitation goals and services within a number of the referral sources and possibly there is a reluctance on the part of the Division of Vocational Rehabilitation to accept those more difficult cases, with which closure is not so expeditious.
7. It was reported by many agencies and community groups who referred clients to the Division of Vocational Rehabilitation that there was little or no feedback to the referring agency as to the dispensation of the referred case.

Recommendations:

1. An investigation should be made into the desired role and boundaries of the Division of Vocational Rehabilitation. This investigation should particularly concern itself with the question of whether the Division should be an agency concerned only with vocational rehabilitation or a general rehabilitation agency which concerns itself with all types of rehabilitation regardless of rehabilitation goals. It should also explore the need to concretize the boundaries of the Division by giving adequate general

descriptions of those clients that can be served. Some committee members felt that the Division of Vocational Rehabilitation was in violation of its boundaries by serving school drop-outs and certain elements of the poverty population.

2. The possibility of removing the Division of Vocational Rehabilitation from under the Department of Public Instruction and establishing it as a separate, autonomous department should be explored by the legislative branch of the state government. As a department, it would have more budgetary control of its monies which in turn would allow it to extend its services and program development in a more realistic manner. It would provide Vocational Rehabilitation with the political status necessary to deal directly with those legislative problems and actions encountered in funding such an agency. Providing it with more autonomy, would allow the development of better cooperation and coordination with those agencies and groups which are not under the Department of Public Instruction.
3. Consideration should be given to the establishment of a Governor's Council on Rehabilitation. This council should be made up of lay and professional persons and should be responsible only to the Governor. The major purpose of this council would be to coordinate rehabilitation activities throughout the state. One method to accomplish this is by establishing county or regional councils on rehabilitation. Professional coordinators should be hired to serve these councils. This type of coordination should help to extinguish extreme overlapping of services and expedite the rehabilitation of the clients involved. It is felt that it would be economically sound to hire professional coordinators, for if even a fraction of the overlapping in services is prevented, many dollars of the taxpayers' money would be saved. Duplication of rehabilitation services is commonly found in most communities where agencies do not know of or understand the services that are being provided by other agencies. A coordinator who is not responsible to any single agency and who has no funds to implement programs would seem most desirable to alleviate the problems of coordination. Since he would have no investment except coordination and no responsibility except to the local council, he should not be burdened with those elements that plague most agencies; i.e., agency jealousies and defense of their own boundaries.¹
4. The Division of Vocational Rehabilitation should set up a licensing board, within the Division, to set standards and license those vendors, facilities, workshops, half-way houses and agencies from which they purchase rehabilitation services. The setting of licensing requirements should help to eliminate most of the inconsistent, inadequate and inferior services that are now being purchased for Vocational Rehabilitation clients.
5. An investigation should be made into the reasons for high turn-over rates of Vocational Rehabilitation personnel. The Advisory Committee suggested the following areas to which this investigation might direct itself:
 - a. salary and increments: The committee saw the high turn-over rate of V.R. personnel as a multi-faceted problem but felt that one important factor might be the salary range of V. R. personnel as compared to the salaries of positions comparable responsibilities and skills in other agencies.
 - b. supervision: Does the type of supervision that is now practiced in Vocational Rehabilitation allow for the development of an autonomous individual who has the opportunity to use his ingenuity, creativeness, moral inwardness, skills, intellectual abilities and self-responsibility in carving himself a professional niche? Or does the supervision debilitate the counselor by creating anxiety, tension and in general an uncomfortable worker through its rigidity and pressure for closures?

¹See Appendix III for description of qualifications and skills a "Rehabilitation Coordinator" should possess.

- c. consultative services: Does the Vocational Rehabilitation worker receive sufficient and expert consultative services from the state level staff?
 - d. training: Is adequate in-service training made available to the worker in order that he feels comfortable and adequate in the type of work he is doing?
 - e. community image: Does the Vocational Rehabilitation Agency have an image in the community which demands sufficient respect, that a young, professional worker prides himself in his position as a Vocational Rehabilitation Counselor?
 - f. materials and work space: Does the Vocational Rehabilitation worker have sufficient materials, well designed office space and adequate work areas to carry out the tasks that are expected of him?
6. A thorough investigation should be made of those cases closed as not feasible for rehabilitation services. The investigation should try to discern if the referring agency did not understand the purpose of and services provided by the Division of Vocational Rehabilitation, if it is an attitudinal problem of the agency or both.
 7. Methods and procedures should be established in order that adequate feedback is given to those agencies, groups and persons referring clients to the Division of Vocational Rehabilitation. This type of activity would enhance cooperation, communication and coordination between Vocational Rehabilitation and the referral source.

II. Rehabilitation Houses

A. Problems:

1. The major problem reported in connection with the development of rehabilitation houses was the lack of organization and structure on the part of state level Vocational Rehabilitation and Mental Health in planning the development of these community based facilities. The agreement between the state level personnel and the community board was nebulous to the point that no one person actually knew in what he was getting involved. Many of the state level personnel involved at the beginning of development were transferred and moved to other jobs leaving state level development in inexperienced hands. There was neither an adequate budget or program established so that persons planning could say this would cost this much or that this will work and that will not work.
2. There is not adequate screening and preparation of clients who are brought to the rehabilitation houses. Persons brought in from mental hospitals have been in these institutions for several years. There is not adequate structure, staff or facilities to provide these persons with the follow-up that is necessary. Ninety per cent of the psychiatric patients are still on medication but it is felt that when these patients get to the half-way houses, all of this would be taken care of. It seems that the assumption has been that since these people are going to be rehabilitated, there is no need for psychiatric follow-up or follow-up of medication. The Pines, a rehabilitation house in Charlotte, reports that the majority of psychiatric cases they received are of the severely disabled type and that many persons with lesser degrees of disability should be served by the house but are not referred to them.
3. When the Durham Rehabilitation Houses were first opened there was a rapid fire succession of vocational rehabilitation counselors assigned to the houses. This high turn-over seemed to be due to several factors. Personality conflicts appeared to be one of the major factors; these, however, seemed to be based on conflicting philosophies about rehabilitation between the rehabilitation house staff and board and vocational rehabilitation agency personnel. Another factor was the overloading of the V. R. Counselor with too many jobs. The counselor had to make administrative

decisions, approve all financial arrangements, provide counseling, place the clients in training and on jobs and work with the local board of the house. In addition to all of these responsibilities, he was carrying a caseload which was unrelated to the rehabilitation house.

4. The fact that house personnel do not have adequate consultation services from a qualified psychiatrist, social worker or psychologist and do not have a "blow-off valve."¹ in emergencies creates friction between the residents, house personnel, V. R. Counselor and the local board.
5. It is difficult for the V. R. Counselor to work individually with residents of the rehabilitation house about personal problems because he has too much power. He is capable of controlling this client's life; i.e. sending him back to the institution, placing him on a job, placing him in training, determining the money he has to spend, et cetera. This kind of power produces dependency reactions as transference² in counseling which create a problem in developing an adequate relationship to deal with the personal problems of a former institutionalized client attempting to adjust to the community.

B. Recommendations:

1. A rehabilitation house specialist³ should be employed by the Division of Vocational Rehabilitation at the state level. This would be an individual who can be used by those communities which are in the process of establishing rehabilitation houses. This specialist hired and placed in the position of working with these community rehabilitation houses without adequate training and understanding of the problems encountered in the development and operation of these facilities would so disillusion the community persons involved that he might be more disruptive than helpful, since one of their major complaints is *the lack of expert help from the state level agencies*.
2. An investigation should be made into the budgets of existent rehabilitation houses so that aid might be given to those houses that are having significant difficulties with their finances. This does not, necessarily, mean aid in the form of monies but, possibly, in organization and structure.
3. An investigation should be made of the "follow-up services" available to each house with the intent of bringing those services, when found deficient, up to the level necessary to provide adequate rehabilitation for the residents involved.
4. An investigation should be made of the screening and referral processes from vocational rehabilitation facilities in cooperative agreements with institutions. This investigation should include a close examination of the clients placed in rehabilitation houses; i.e., the clients' degree of disability, the return rate to the institution, the types and frequencies of emergencies these clients have created in the house and the rehabilitation services received before referral to the house.

¹"Blow-off valve" is a term that was used in the public hearings. It is the understanding of the committee that this represents an individual with whom the rehabilitation house personnel can have a catharsis. That is, an individual who will listen to and understand the problems and conflicts encountered by the house personnel, which produce emotional tension and/or anxiety. Through an expressive reaction (catharsis) there should be a relaxation of emotional tension and anxiety.

²Dependency reactions as transference is a type of behavior expected of a client with deep emotional problems when a person with the authority and power of his vocational rehabilitation counselor attempts to provide personal counseling or therapy. There is a tendency on the part of the client to overvalue the characteristics of the counselor. This provides for an unstable relationship in which the client thinks of the counseling as a magical means to power and security. The client will demand more and more of the counselor. The counselor being unable to fulfill the client's demands will aid in the production of hostility and contempt toward himself. The client may also view the counselor as one who is capable of injuring and controlling him. In this case the client may develop intense fear of the counselor. When the client has a hostile image of his parents, he usually applies this attitude to all authority figures.

³See Appendix IV for description and qualifications of a "rehabilitation house specialist".

5. A social worker should be hired on a permanent basis for those houses which do not have one employed at the present. This professional would be expected to provide group counseling for all residents of the house and individual counseling concerning personal problems of the residents when necessary. He should also be concerned with the client's involvement with his family and provide aid when possible to improve the client's relations with his family and community. This professional should also be available to the house personnel as a consultant and a "blow-off valve," to help them tolerate the tension and frustrations which develop when working with the psychiatrically ill and the mentally retarded.
6. A rehabilitation counselor should be appointed with the singular duty of providing services for the rehabilitation houses of each community. With this limited caseload he should be capable of providing individual and group vocational rehabilitation counseling, make administrative decisions, develop community relationships, place the residents on jobs, follow-up those persons whom he has placed and to the degree necessary follow-up those who have left the house.
7. An investigation should be made into the need of a permanent residential facility for those persons who continue to need a sheltered living situation after they have left the rehabilitation house. If there is a need for such a facility, funds should be sought to develop a pilot facility of this nature.
8. The Division of Vocational Rehabilitation should pay the rehabilitation houses for those spaces that are available, whether they are filled or not. If this were paid for at the same rate that spaces are paid for today, it would provide a regular monthly income which would allow the house to provide a more consistent and adequate type of service. It would not make it necessary for the houses to hang on to clients who should be placed in the community, or accept clients who are not ready for the half-way house, just to keep their heads above the water.

It would also allow new houses to develop at a more reasonable rate than has been expected in the past. Past practices have been to open the house one day and have it full of clients the next. This practice does not allow for an adjustment period for the house or the house personnel and does not provide time for adequate program development.

III. Sheltered Workshops

A. Problems and Needs:

1. One of the major problems mentioned by the workshop directors participating in the public hearings was the acquisition of equipment through the State Division of Vocational Rehabilitation. In most cases it took six months after requests for equipment were submitted before any began to arrive. It was a year to a year and a half before all of the equipment requested arrived.

In addition to the delay in receiving the equipment, it was often not adequate for the needs of the workshop or it was overly adequate belonging in a much heavier industry. The workshops felt that a great deal of money and time is wasted in the present method of acquiring equipment.

It was also felt that new workshop directors had very little knowledge of the types or sizes of equipment needed to establish a workshop.

2. Workshop directors felt that the time allowed for training Vocational Rehabilitation clients was too short. The time usually allotted is one month for evaluation and a maximum of six months for training. One workshop director stated that six-months training should be the minimum for mentally retarded clients rather than the maxi-

mum. It was admitted that evaluation can be extended for certain clients to 18 months but that it is difficult to get the Division of Vocational Rehabilitation to go along with this. The workshop directors claim the funds for extended evaluation have strings.

3. A third problem concerns the fees paid. These are \$140.00 for one months evaluation and \$60.00 per month tuition for training. A recent survey indicates that it takes \$105.00 to support an individual in the shop for one month. The shop is having to provide the difference between \$105.00 and \$60.00.
4. The major complaint of the workshops was the paucity of time the V. R. Counselor actually spent in contact with the V. R. clients. One workshop director indicated that V. R. clients in his shop saw the V. R. Counselor on an average of about five minutes a month. It was stated by all workshop directors who participated in the public hearings that their clients needed vocational rehabilitation counseling and in addition to this there were many emergencies and personal adjustment problems that arose which demanded counseling services of the type the V. R. Counselor could furnish.
5. The panel members for the public hearings seemed to sense inadequate training and a lack of expert support for sheltered workshop directors. It seems that there are a limited number of persons in this state with sufficient knowledge of workshop philosophies and functions who can serve as adequate consultants to community workshops.
6. A trend, which seems to be establishing itself in a number of the workshops in this area, is to incorporate a high percentage of terminal clients in the shop. Most of these shops were established as transitional shops with the expectation that a high percentage of individuals would be evaluated and trained and moved to competitive employment. In some shops today over 70% of the clients are terminal. A number of the clients are involved in activities which you would normally find in activity centers. This is contrary to basic workshop philosophy, which makes the assumption that through *productive* and *meaningful* work; training, therapy and rehabilitation can be accomplished. When activities other than productive and meaningful work are carried on in the areas in which an attempt to work is being made it is distracting, destructive to work attitudes of the clients who are involved in work and limits the value of the workshop as a rehabilitation facility.

B. Recommendations:

1. That a position for a "specialist in workshop development and administration"¹ be established at the state level. This person would serve as a consultant to developing workshops and those already in existence.

Since it is highly unlikely that a person with the skills and knowledge necessary to serve as this specialist is available, it would be the task of the Division of Vocational Rehabilitation to develop this specialist by providing adequate training and experiences to a sensitive and capable individual who plans to make rehabilitation a *professional* career.

2. The Vocational Rehabilitation Counselor who is serving clients in the sheltered workshop should have a caseload sufficiently limited that it would allow him to spend at least two hours of counseling time each month with each client he has in the sheltered workshop. This is less than thirty minutes a week.
3. Training for workshop directors should be made available by the Division of Vocational Rehabilitation to provide them with more security and competence at their jobs. At the minimum, this training should include the following areas:

¹See appendix V for description and qualifications of a "specialist in workshop development and administration."

- a. Philosophy and structures of the sheltered workshop
 - b. Supervision of personnel
 - c. Sub-contract procurement and bidding
 - c. Sub-contract procurement and bidding
 - d. Finances of the sheltered workshop
 - e. Transportation
 - f. Vocational Training in a sheltered workshop
 - g. Vocational Evaluation in a sheltered workshop
 - h. Personal and social adjustment training in a sheltered workshop
 - i. Vocational Counseling
 - j. Community Organization
 - k. Public Relations
 - l. Competitive Work Placement
 - m. Program development in a sheltered workshop
 - n. Budget Development
 - o. Work Task Analysis
 - p. Recreation and leisure time for the sheltered workshop client
4. An investigation should be made into the time allowed by the Division of Vocational Rehabilitation for vocational evaluation and training in the sheltered workshop. This investigation would be to determine if those services allowed under the law are being adequately used.
 5. An investigation of the fees paid for vocational evaluation and training should be made. Through this investigation it should be determined what percentage of the cost of evaluating and training an individual should be absorbed by the workshop through sub-contracts and sales.
 6. If a sheltered workshop is established to train and rehabilitate transitional clients, it should set a definite percentage of positions in the shop as terminal; i.e., 40%, 50% or what have you, and it should not exceed this percentage. If the percentage of clients in a workshop is too heavily weighed toward the terminal client, difficulties in training the transitional client may arise because an atmosphere of non-movement exists. This atmosphere of non-movement not only affects the clients but the trainers. An attitude is developed in which the trainer and the client feel that it is safer to stay in the workshop rather than risk the world of competitive employment and possible failure.

If some of the clients in the shop are involved only in those activities you would find in a daily activity center, they should be segregated from the areas in which productive work is being performed. These kind of activities tend to disrupt and distract from the training and work of the more productive individuals.
 7. Personal and Social Adjustment classes should be provided for the mentally retarded in the sheltered workshop. It is suggested, however, that cooperative arrangements be made between the workshop and community colleges and adult education programs to provide this type of training for it is a responsibility of these educational services to provide adult education for persons no longer involved in regular classroom work in the public schools.
 8. An investigation should be made into the manner of purchasing equipment for sheltered workshops to see if there is not a more expeditious and satisfactory manner of selecting and delivering the needed equipment.

IV. Physicians

A. Problems and Needs:

1. The fees for medical examinations and doctor office visits for Vocational Rehabilitation clients are less than normal fees. For example, it may cost the general population nine dollars for a visit to a doctors office while Vocational Rehabilitation pays only \$7.50. The difference in cost is made up by the staff of the doctor's office and patients from the general population.
2. In many instances, fee schedules and other vital information are not forwarded to physicians in a proper and expeditious manner. In certain instances, physicians had not received important information which would have facilitated his relations with the agency and clients.
3. Due to a shortage of doctors and para-medical personnel, the paper work required to work with Vocational Rehabilitation clients has become a major problem with the medical services. It is felt that with other state and federal agencies entering into programs which pay for medical services that the paper work problem will become more acute in the very near future.
4. During the public hearings, there were suggestions that some V. R. clients may receive hurried and incomplete examinations by certain physicians because of the lower fees paid by V. R. It was stated that some physicians refuse to see V. R. clients because of the low fees.
5. There is some concern among psychiatrists because emergency hospitalization for psychiatric patients is approved by Vocational Rehabilitation only for certain types of treatment. The psychiatrists also stated that some fees paid by V. R. are less than 50% of the normal fees.

B. Recommendations:

1. An investigation into the fee schedule for medical services should be initiated. This investigation should concern itself with:
 - a. The adequacy of the fees now being paid.
 - b. Are Vocational Rehabilitation clients receiving the quality of medical services the reglar patient would receive?
 - c. Methods of developing more adequate, cooperative relationships with physicians.
 - d. Methods of getting vital information to all physicians concerned in the most expeditious manner.
 - e. Methods of revamping the paper work required for Vocational Rehabilitation clients in order less of the physician's time is spent filling out forms.
2. Emergency psychiatric services for Vocational Rehabilitation clients should be investigated to determine if the types of services authorized by the agency should be expanded to include some types of emergency care which are now excluded.

V. The Older Client

A. Problems and Needs:

1. Persons over 65 deal with losses in the social realm.
2. They experience problems in the biological realm where there is a decline in all the organs systems.
3. They experience a loss of family and friends through the aging process.

4. There are three groups of aged persons who need services similar to those that can be offered by Vocational Rehabilitation:
 - a. An institutionalized group which is liable to develop the disabilities of disuse to a greater extent than those persons remaining in the community. These people need an opportunity to participate within their limits in creative and/or productive activity.
 - b. A group of people who are living at home but are unable to work in competitive employment. Their needs are similar to those of the first group.
 - c. A group of people living at home who are able and willing to work. This group of people need help in adjusting to work situations at their advanced ages. They need help in seeking those types of jobs that are productive and rewarding but are still within their physical limitations. Quite often special training, counseling and selective placement are required.

B. Recommendations:

1. It is recommended that Vocational Rehabilitation expand its services to the aged, specifically, in those areas where it shows the most competence; i.e., vocational training, vocational rehabilitation counseling, vocational evaluation, sheltered work placement and selective job placement.
2. Special training be provided selected personnel from Vocational Rehabilitation to work realistically with the vocational problems of the aged.

SUMMARY

Although the work of this committee has been sporadic, the information collected has been both eye-opening and exciting to the members. As we began to compile information which we had obtained in the public hearings and the regular committee meetings, there were several problems and gaps which were repeated or showed evidence of being major deficiencies in the Vocational Rehabilitation Program.

1. The lack of the Vocational Rehabilitation Counselor's time in actual counseling contact with the client. This problem was repeated over and over in the public hearings. It is the feeling of the committee that this is an emergency problem and should be dealt with at the earliest possible moment.
2. The lack of *expert* consultative help in the development of Vocational Rehabilitation Programs at the community level. The experts needed for the development of these programs may not exist today, but they should be developed and trained by the Division of Vocational Rehabilitation.
3. There is a pressing need for coordination of rehabilitation services in the communities to prevent the expensive overlapping of services that is now taking place. Consideration of methods to alleviate this problem should receive a high priority.
4. The Vocational Rehabilitation Services that are now being offered the aged are inadequate and insufficient. There is a growing population of aged persons. Programs should be developed *now* for this group of potential clients before it becomes an unmanageable problem.
5. The high turn-over rate of V. R. personnel presents problems in the development of new programs, the administration of old programs and cooperation and coordination with other agencies and groups. An investigation of this problem should be immediate.

APPENDIX III

Rehabilitation Coordinator:

It is necessary that the Rehabilitation Coordinator know himself. There are a number of factors in his characterization which will directly affect the development of relationships with the agency and community persons with whom he has to work to coordinate rehabilitation activities. It is necessary that the coordinator know of these personality traits, can recognize them in himself and relate them to cooperation, coordination and thought itself.

1. Prejudices, feelings and beliefs about physically, mentally and socially disabled individuals.

If the coordinator approached an individual, say someone on the board of county commissioners, telling him about disabled persons and programs for the disabled in positive terms but his feelings convey doubt and fear about the effectiveness of the program and whether it is really worthwhile to spend so much money on the disabled, then he can expect failure in putting across his program. In order to be truthful with the community person requires the coordinator to have knowledge of his feelings as well as the intellectual processes required in developing communication, *cooperation* and coordination. Instead of trying to present a facade to shadow one's feelings *the Rehabilitation Coordinator should relate the knowledge of his feelings to thought in general and appear as a transparent being whose words and behavior are in line with his feelings.*

Persons with whom the coordinator will wish to develop cooperative relations will be surprisingly perceptive to facades so many professionals build to protect their true feelings and prejudices. There is no other thing, with the exception of open hostility, that so readily makes the approached individual uncomfortable and insecure in a developing relationship as a conflict between feelings and overt behavior in the professional.

2. Abilities to express self.

The coordinator should be capable of seeing and understanding the patterns of behavior and speech which he uses to get across information and concepts about the disabled persons and programs for them. It is necessary that he be able to recognize and criticize his expressive behavior in order to prevent falling into ruts, presenting a "canned speech," responding inappropriately, presenting a false picture and in general making an ass of himself. A continual investigation of his expressive behavior is a requirement for the coordinator.

3. Trustworthiness, dependability and consistency.

In coordination, the above mentioned characteristics are invaluable. A Rehabilitation Coordinator who conveys the impression to the community person that he is not dependable, not trustworthy or inconsistent readily destroys the relationships that are so necessary to his task. It is easy for a coordinator to feel that he exhibits all of the above positive traits while his behavior appears to the community person as representing negative traits. This self deception is easily seen in very egocentered persons who create difficulties out of ignorance of themselves. The egocentered persons are the ones who destroy relationships and can never understand why the other parties feel antagonized.

If communication breaks down with the community persons, the investigation of this breakdown should begin with the Rehabilitation Coordinator himself, for he is the professional in this operation. It is his job to develop and maintain coordination, communication and cooperation. He should make an attempt to understand the characteristics of the other parties (individuals, agencies, groups, etc.) involved and develop a relationship with these characteristics in mind. Understanding the other parties first requires that the coordinator know himself; for as soon as he comes in view of the other individuals, he becomes, to an extent, a determinant of that individual's behavior. An egocentered individual,

a person capable of seeing a situation only from his viewpoint, might burst into a relationship, blow a project and never understand the behavior of the other parties involved because he was totally unaware of his own behavior. Before he can adequately investigate the breaking down of relationships he must know his involvement in the relationship. Before he can know his involvement he must know himself.

4. Anxieties, dominance by authority and courage.

Because fear can readily affect the development of a relationship, the Rehabilitation Coordinator should be aware of those anxieties he possesses and methods of dealing with them. Being so uncomfortable with anxiety (the fear of being rejected or of failing), the coordinator may unconsciously prompt the community person to say "No," in order to terminate the conference or interview and end this feeling of uncomfortableness.

The ability for the coordinator to dissociate his ego from the coordination activity and depend upon his skill and knowledge to perform the necessary operations is the solution to this problem.

Some persons are so dominated by authority and persons of power that they cower before them, therefore, making truly cooperative relations with these individuals impossible. This is not unnatural and is found in many young professionals. It is a carryover from childhood when one depended upon authority and power (parents, teachers, bosses, churches, older persons) for direction and judgment. However, it can be disruptive to coordination activities, if the community person represents a person of authority or power and the person dominated by authority has difficulty in expressing his concepts and feelings. Essentially what happens is the coordinator becomes a "yes man" to the community person of power and he finds himself saying yes to false concepts and misinformation.

Dominance by authority also promotes an approach to the community person of power in which the coordinator use quasi truths. Statements about programs and conditions are tempered to such an extent that the community person is expected to say "yes". With disregard to the reality of the situation, the coordinator develops a package with nice wrappings and ribbons and delivers it to the community person which the coordinator hopes he will accept before it is unwrapped, revealing the true characteristics of the situation. It is not that the program, project, facility or "what have you" is not valuable or productive, but that the community person has been deceived. He has not had the full opportunity of the coordinators knowledge and skills in coordinating the development of this element.

The really frightening part about coordination activities of this type is that the coordinator in his fantasy believes that he has really done a good job. That he, in a promotion of this type, has utilized his wit and the tools of the trade well and has sold the community person a package that he would not otherwise accept.

Courage is an especially important characteristic of the coordinator. A great deal of coordination depends on the coordinators ability to stick to his convictions, that is to lay his reputation on the line. He makes statements about programs and disabilities which he feels are as accurate and true as possible with the information he possesses. His courage is based on his knowledge, skills and judgment.

The "hang up" comes when the coordinator has so little knowledge of himself and is so insecure that he is afraid to rely on his own judgments. Being afraid of his judgments he is unable to develop convictions about his activities. He is the coordinator who says, "I don't really know about this project but Raleigh says it is good." Courage is developed by realistically knowing what one knows and can do and the limitations within himself. If the coordinator knows himself he can gain the knowledge and skills to make sound judgments and develop the necessary courage to stand by his convictions and program.

APPENDIX IV

Rehabilitation House Specialist:

The Rehabilitation House Specialist should be a college graduate but the type of degree or discipline under which he was trained is not of the utmost importance. He should be innovative, intellectually bright and capable of working with community boards, state agencies and institutions. He should be secure and aware of himself to the extent that he is comfortable relating to physicians, psychiatrists, community leaders, house parents, psychiatric and mentally retarded clients, and all persons professional and otherwise working with the mentally handicapped.

The type of individual required for this position is not likely to be found in the labor market today. He will have to be developed and trained by those agencies needing his services. The agencies who hire and develop him will have to accept the responsibility of support for him if he is expected to operate as a specialist. It will be necessary that he have adequate and expert consultative aid with technical and esoteric problems; i.e., legal, medical, financial, et cetera.

His salary should be at a level to provide sufficient financial security, in order that he will not have to keep one eye over his shoulder for creditors who are supplying him with the basic material needs. This in itself can have a lot to do with the personal security required in the position, Rehabilitation House Specialist. Anxiety over money can be one of the most debilitating factors with regards to a worker's productivity, when his major tasks are involved with relationships to other persons and groups.

The agency should also concern itself with the type of supervision supplied this specialist. Supervision should not be of the concrete, authoritative type but that of support allowing for considerable autonomy. Autonomy is necessary in developing cooperative relationships with individuals and groups. It is also of prime importance in dealing with authority figures outside of his agency.

The training and development of this individual should be assumed by the Division of Vocational Rehabilitation and the Department of Mental Health. At the minimum he should receive training and exhibit competence in the following topics:

- a. Basic information about the types of disabled persons residing in the Rehabilitation Houses.
- b. Follow-up services for the mentally retarded and mentally ill entering the Houses from institutions.
- c. Program development under Vocational Rehabilitation and Mental Health auspices.
- d. Community organization.
- e. Building codes, zoning laws and health and safety requirements for multiple living situations.
- f. Information about the problems of sub-professional personnel develop in working with individuals who have mental disabilities.
- g. Community social services.
- h. Vocational rehabilitation processes for the mentally retarded, recovered mentally ill and persons with other disabilities likely to need the services of the rehabilitation houses.
- i. Budget development for rehabilitation houses.
- j. The processes of screening and placing individuals in half-way houses.

APPENDIX V

Specialist in Workshop Development and Administration:

Since it highly unlikely that a person, with the skills and knowledge necessary to serve as a Specialist in Workshop Development and Administration is available, it would be the task of the Division of Vocational Rehabilitation to develop this specialist by providing adequate training and experience to a sensitive and capable individual who plans to make rehabilitation a professional career.

There are certain abilities, experiences and training this individual should have:

- a. He should understand the philosophies, concepts and general functions of a workshop as an evaluation, training and therapeutic resource.
- b. He should be familiar with equipment that is needed in workshops and know how to expedite the acquisition of this equipment as it is needed. This would include everything from office equipment, to heavy machinery, to utilities, to materials such as lumber and wire.
- c. He should understand and know how to set up bookkeeping systems for sheltered workshops.
- d. He should have knowledge and experience in acquiring sub-contracts. He should be particularly knowledgeable on how to go about bidding.
- e. He should be knowledgeable in vocational evaluation systems and techniques.
- f. He should be capable of working with and influencing local boards of workshops.
- g. He should know how to go about developing adequate training situations from the types of work normally found in a sheltered workshop.
- h. He should know about selecting and designing facilities in which to house a sheltered work shop.

INTERAGENCY COORDINATION OF SERVICE PROGRAMS

As the result of the North Carolina Study in Vocational Rehabilitation, there has been no interagency coordination of service programs per se. However, at the time the study was initiated, visits were made to each of the state offices of state social service programs to acquaint each particular agency with the North Carolina Study in Vocational Rehabilitation, its goals and objectives. During these interviews permission was requested to ask local service units for their cooperation and assistance. The positive response to this request was very gratifying. Another source of great satisfaction has been the cooperation and help received by the Study from many local service agencies in such areas as planning and conducting public hearings and participating in the Interagency Relationship Study reported on the next pages.

INTERAGENCY RELATIONSHIP SURVEY

Early in the North Carolina Study on Vocational Rehabilitation, it became very apparent that coordination of agency services at the community level is a crucial contingency for the development of an effective and efficient Vocational Rehabilitation program. On the following pages is a report of a study conducted by Mr. Donald A. Dunson, Community Research Coordinator. Mrs. Shirley Crowder, the Project's Research Assistant provided much help in the converting of raw data gathered into the final report.

The Division of Vocational Rehabilitation assisted in the completion of this project by assigning 26 rehabilitation counselors and supervisors to help with the vast amount of field work involved. The efforts of many of the counselors were productive and very satisfactory. It was disappointing, however, that there was a lack of interest and cooperation by *some* of the VR personnel involved. This lack of enthusiasm resulted in many people from certain areas of the state having no opportunity to take part in the survey.

It is hoped that all agencies who did take part in the Interagency Relationship Survey will scrutinize the results and ask appropriate questions where deficiencies are seen. It is unfortunate that space and time does not permit the inclusion of *all* the pertinent statements made by people who took part in the personal interview section; it is felt that their comments are worth a thousand statistical tables.

INTRODUCTION

The North Carolina Rehabilitation Study, determining that a high degree of communication, coordination, and cooperation was vital to the success of all social programs, conducted a survey which it hoped would demonstrate how agencies relate to each other. The purpose of the project was to learn (1) if agency personnel knew what other agencies offered in the way of service and (2) what they, as professionals, liked or disliked about the way these services were administered. It was realized from the beginning that this survey would not answer all questions about interagency relationships but it was hoped that some idea would be gained regarding what people think and say about their work with others.

It was the project's bias that one of the main reasons there was not a high degree of cooperation was because relatively little specific information was available regarding the nature of the interagency relationships professed to be desired not has there ever been a careful analysis of the obstacles to be overcome if concerted efforts rather than a series of segmented services was to be achieved accompanied only by expressions of intent to work together.

Some of the questions to be answered were: How much do other agencies work with or come in contact with disabled people; How much do these agency personnel know about the established Vocational Rehabilitation Agency; How do these people perceive the Vocational Rehabilitation Agency in terms of professionalism, cooperativeness and contribution to the advancement of society?

Ten counties were randomly selected, by the use of a random number table, from the one hundred counties in North Carolina. It was felt that through such random selection a more accurate picture of interagency relationships could be drawn. Vocational Rehabilitation counselors interviewed the directors of social service agencies in the ten counties and distributed questionnaires to directors and all professional persons in these agencies. A total of 372 questionnaires were returned.

Another part of the project involved six purposively selected counties: three of these (Durham, Pitt, and Transylvania) having been previously studied in a population survey conducted by North Carolina State University; two (Gaston and Rutherford) selected at the request of agency personnel in the counties; and one (Mecklenburg) because of its uniqueness to the state. A total of 555 questionnaires were answered by persons in these counties.

It is hopeful that the results of this survey will prove useful and will raise many questions. It is hoped that persons having questions or wishing to discuss these findings will contact the Division of Vocational Rehabilitation or the State Commission for the Blind. Any response or ideas to improve interagency relationships will be appreciated.

Included in this report are: (1) statistical findings from the ten counties randomly selected and scientifically studied (2) a copy of the questionnaire we used (3) results obtained from the six counties we also worked with on the project (4) some quotes regarding the questions not tabulated (5) counties surveyed (6) counselors involved.

There are many more words that could be written here but the results speak for themselves. Professionals reading this report will know of the pitfalls in a research project of this type and should be cautious of their interpretation of the results.

TEN RANDOMLY SELECTED COUNTIES

Counselors	County
C. E. Henderson	Ashe
E. W. Brafford	Caswell
V. R. Cashwell	Cumberland
P. D. Edwards	
Asa Jackson	
J. C. Beale	Davidson
J. A. Harden	Duplin
H. G. Sawyer	Hertford
J. H. Mehaffey	Jackson
J. A. Harden	Onslow
Asa Jackson	Robeson
Mrs. George Ball	Wake
W. A. Christopher	
C. R. Colvin	
R. A. MacGillivray	

SIX PURPOSIVELY SELECTED COUNTIES

P. W. Dieffenderfer	Durham
Mrs. Augusta B. Turner	
F. H. Thompson	Pitt
C. L. Ousley	
S. R. Patton	Transylvania
Melvyn Garr	Gaston
Frank Hamrick	
A. G. Eller	Rutherford
J. D. Kibler	Mecklenburg
C. F. Mansfield	
W. H. Paris	

Table 11

**Responses to Interagency Questionnaire from
Persons in Ten Randomly Selected Counties in North Carolina**

AGENCY respondent employed in:	<u>NUMBER</u>	<u>PERCENT</u>
Welfare Department	106	28.5
Public Schools	60	16.1
Employment Security Commission	36	9.7
OEO and related programs	35	9.4
Sheltered Workshops	10	2.7
Health Department	35	9.4
Agricultural Extension	15	4.0
Probation	18	4.8
Mental Health	8	2.2
Agencies for Special Disabilities	1	0.3
Social Security	5	1.4
Hospitals	9	2.4
Salvation Army	3	0.8
Associations	2	0.5
Higher Education	9	2.4
Counseling, guidance	4	1.1
Other	10	2.7
Not Given	6	1.6
TOTALS	<u>372</u>	<u>100.0</u>
SEX of respondent		
Male	168	45.2
Female	193	51.9
Not Given	11	2.9
TOTALS	<u>372</u>	<u>100.0</u>
RACE of respondent		
White	328	88.2
Nonwhite	29	7.8
Not given	15	4.0
TOTALS	<u>372</u>	<u>100.0</u>

AGE of respondent	NUMBER	PERCENT
20-34 years	155	41.7
35-44 years	81	21.8
45-64 years	104	27.9
65 years and over	3	0.8
Not given	29	7.8
TOTALS	372	100.0

TIME EMPLOYED with agency

Up to 1 year	57	15.3
1 year, less than 2	46	12.4
2 years, less than 5	97	26.1
5 years, less than 10	53	14.2
10 years, and over	96	25.8
Not given	23	6.2
TOTALS	372	100.0

EDUCATION of respondent

High school diploma	12	3.2
B.A., B.S.	211	56.7
M.A., M.S.	75	20.2
Ph.D., Ed.D., M.D.	11	3.0
Nursing	21	5.6
Other	10	2.7
Not given	32	8.6
TOTALS	372	100.0

1a. Do you work with disabled persons?

Yes	288	77.4
No	77	20.7
Not given	7	1.9
TOTALS	372	100.0

1b. Approximate No. Monthly

None	77	20.7
1-5	96	25.8
6-10	36	9.7
11 or more	85	22.8
Not given	78	21.0
TOTALS	372	100.0

2a. To whom do you refer the disabled people whom you serve or encounter?¹	<u>NUMBER</u>	<u>PERCENT</u>
Welfare	65 of 434	15.0
Public Schools	8 of 480	1.7
Employment Security Commission	14 of 504	2.8
OEO and related programs	2 of 505	0.4
Sheltered Workshops	10 of 530	1.9
Health Department	25 of 505	5.0
Probation	2 of 522	0.4
Vocational Rehabilitation	217 of 540	40.2
Mental Health	39 of 532	7.3
Agencies for Special Disabilities	13 of 539	2.4
Social Security	27 of 535	5.0
Hospitals, clinics	73 of 531	13.7
Salvation Army	4 of 537	0.7
Associations	8 of 538	1.5
Higher Education	1 of 531	0.2
Other	32 of 536	6.0
TOTALS	<u>540²</u>	

2b. Method of Referral

Oral	168	35.5
Written	144	30.4
Personal contact	111	23.5
Advise client	15	3.2
Appointment	8	1.7
Thru another agency or person	22	4.6
Other	5	1.1
TOTALS	<u>473³</u>	<u>100.0</u>

3. How accessible do you consider your office to persons in need of your services?

Very accessible	243	65.3
Fairly accessible	102	27.4
Not very accessible	13	3.5
Not given	14	3.8
TOTALS	<u>372</u>	<u>100.0</u>

¹ The figures in this table indicate the number of **other** agencies who refer clients to a given agency, eg. out of 434 responses from agencies other than Welfare, 65, or 15%, indicated that clients were referred to Welfare.

² This total differs from the others because more than one agency might have been listed in this question.

³ This total differs from the others because more than one method might have been listed by the same person.

4. List in order the 5 social agencies you find most cooperative with your own agency.¹

	<u>NUMBER</u>	<u>PERCENT</u>
Welfare	237 of 266	89.1
Vocational Rehabilitation	262 of 372	70.4
Health Department	173 of 337	51.3
Mental Health	177 of 364	48.6
OEO and related programs	135 of 337	40.1
Public schools	89 of 266	28.5
Employment Security Commission	82 of 336	24.4
Hospitals, clinics, doctors	82 of 363	22.6
Salvation Army, etc.	62 of 369	16.8
Social Security	56 of 367	15.3
Associations	46 of 370	12.4
Probation, courts, etc.	36 of 354	10.2
Agencies for Special Disabilities	25 of 371	6.7
Agricultural Extension, etc.	21 of 357	5.9
Sheltered Workshops	19 of 362	5.2
Counseling Services	18 of 368	4.9
Higher Education	7 of 363	1.9

5. How familiar are you with Vocational Rehabilitation programs?

Very familiar	59	15.9
Familiar	256	68.8
Not familiar	54	14.5
Not given	3	0.8
TOTALS	<u>372</u>	<u>100.0</u>

7. How many official contacts have you had with a representative of the Vocational Rehabilitation Agency in the past 6 months?

None	71	19.1
1-5	153	41.1
6-10	51	13.7
11-15	28	7.5
16 or more	53	14.3
Not given	16	4.3
TOTALS	<u>372</u>	<u>100.0</u>

¹ The figures in this table indicate the number and percentage of times the listed agencies were selected by other agencies; eg. Welfare was selected by 237 or 89.1%, of the 266 other agencies answering the question.

8. Has the Vocational Rehabilitation Agency or any of their personnel supplied you with information helpful in work with the disabled?	<u>NUMBER</u>	<u>PERCENT</u>
Yes	260	69.9
No	101	27.1
Not given	11	3.0
TOTALS	372	100.0
9. Do you find Vocational Rehabilitation counselors receptive to your referrals?		
Very	229	61.6
Fairly	68	18.3
Indifferent	4	1.1
Other	5	1.3
Not given	66	17.7
TOTALS	372	100.0
10. Has the Vocational Rehabilitation Agency ever asked you for referrals?		
Yes	196	52.7
No	148	39.8
Not given	28	7.5
TOTALS	372	100.0

Table 12

**Responses to Interagency questionnaire from
Persons in Six Purposively Selected North Carolina Counties**

AGENCY respondent employed in:	<u>NUMBER</u>	<u>PERCENT</u>
Welfare	159	28.6
Public Schools	94	16.9
Employment Security Commission	53	9.6
OEO and related agencies	51	9.2
Sheltered Workshops	2	0.4
Health Department	52	9.4
Agricultural Extension	13	2.3
Probation	39	7.0
Mental Health	9	1.6
Social Security	11	2.0
Hospitals	9	1.6
Salvation Army	2	0.4
Associations	5	0.9
Higher Education	19	3.4
Counseling, guidance	28	5.0
Other	7	1.3
Not given	2	0.4
TOTALS	555	100.0
SEX of respondent		
Male	251	45.2
Female	293	52.8
Not given	11	2.0
TOTALS	555	100.0
RACE of respondent		
White	468	84.3
Nonwhite	71	12.8
Not given	16	2.9
TOTALS	555	100.0
AGE of respondent		
20-34 years	245	44.1
35-44 years	127	22.9
45-64 years	120	21.6
65 years and over	2	0.4
Not given	61	11.0
TOTALS	555	100.0

TIME EMPLOYED with AGENCY

	<u>NUMBER</u>	<u>PERCENT</u>
Up to 1 year	115	20.7
1 year, less than 2	66	11.9
2 years, less than 5	156	28.1
5 years, less than 10	94	16.9
10 years and over	96	17.3
Not given	28	5.1
TOTALS	<u>555</u>	<u>100.0</u>

EDUCATION of respondent

High School diploma	1	0.2
B.A., B.S.	315	56.7
M.S., M.A.	159	28.6
Ph.D., Ed.D., M.D.	16	2.9
Nursing	22	4.0
Other	16	2.9
Not given	26	4.7
TOTALS	<u>555</u>	<u>100.0</u>

1a. Do you work with disabled persons?

Yes	406	73.1
No	137	24.7
Not given	12	2.2
TOTALS	<u>555</u>	<u>100.0</u>

1b. Approximate Number Monthly

None	128	23.1
1-5	155	27.9
6-10	50	9.0
11 or more	112	20.2
Not given	110	19.8
TOTALS	<u>555</u>	<u>100.0</u>

2a. To whom do you refer the disabled people whom you serve or encounter?¹

	<u>NUMBER</u>	<u>PERCENT</u>
Welfare	74 of 480	15.4
Public schools	25 of 545	4.6
Employment Security Commission	34 of 586	5.8
OEO and related agencies	6 of 588	1.0
Sheltered Workshops	28 of 637	4.4
Health Department	32 of 587	5.4
Probation	2 of 600	0.3
Vocational Rehabilitation	243 of 639	38.0
Mental Health	39 of 630	6.2
Agencies for Special Disabilities	12 of 639	1.9
Social Security	31 of 628	4.9
Hospitals	66 of 630	10.5
Salvation Army	3 of 637	0.5
Associations	20 of 634	3.2
Higher Education	3 of 620	0.5
Counseling, guidance	5 of 611	0.8
Other	16 of 632	2.5
TOTALS	<u>639²</u>	

2b. Method of referral

Oral	255	44.7
Written	145	25.4
Personal contact	110	19.3
Advise client	12	2.1
Appointment	20	3.5
Thru another agency or person	22	3.9
Other	6	1.1
TOTALS	<u>570³</u>	<u>100.0</u>

3. How accessible do you consider your office to persons in need of your service?

Very accessible	373	67.2
Fairly accessible	124	22.3
Not very accessible	34	6.1
Not given	24	4.3
TOTALS	<u>555</u>	<u>99.9⁴</u>

¹ The figures in this table indicate the number of other agencies who refer clients to a given agency, eg. out of 480 responses from agencies other than Welfare, 74 or 15.4%, indicated that clients were referred to Welfare.

² This total differs from the others because more than one agency could have been listed by a respondent.

³ This total differs from the others because more than one method could have been listed by a respondent.

⁴ Rounding error.

4. List in order the 5 social agencies you find most cooperative with your own agency. ¹	<u>NUMBER</u>	<u>PERCENT</u>
Welfare	282 of 396	71.2
Vocational Rehabilitation	290 of 555	52.2
Health Department	223 of 503	44.3
OEO and related programs	182 of 504	36.1
Hospitals, clinics, doctors	152 of 546	27.8
Mental Health	144 of 546	26.4
Public Schools	92 of 461	20.0
Counseling Services	101 of 527	19.2
Salvation Army	95 of 553	17.2
Associations	86 of 550	15.6
Employment Security Commission	77 of 502	15.3
Probation, courts, etc.	61 of 516	11.8
Social Security	63 of 544	11.6
Sheltered Workshops	53 of 553	9.6
Agencies for Special Disabilities	46 of 555	8.3
Agricultural Extension, etc.	7 of 542	1.3
Higher Education	2 of 536	0.4

5. How familiar are you with Vocational Rehabilitation programs?

Very familiar	73	13.2
Familiar	354	63.8
Not familiar	110	19.8
Not given	18	3.2
TOTALS	<u>555</u>	<u>100.0</u>

7. How many official contacts have you had with a representative of the Vocational Rehabilitation agency in the past 6 months?

None	151	27.2
1-5	215	38.7
6-10	65	11.7
11-15	20	11.7
11-15	20	3.6
16 or more	50	9.0
Not given	54	9.7
TOTALS	<u>555</u>	<u>99.9²</u>

¹The figures in this table indicate the number and percentage of times the listed agencies were selected by other agencies; eg. Welfare was selected by 282 or 71.2%, of the 396 other agencies answering the question.

²Rounding error

8. Has the Vocational Rehabilitation Agency or any of their personnel supplied you with information helpful in work with the disabled?	<u>NUMBER</u>	<u>PERCENT</u>
Yes	321	57.8
No	201	36.2
Not given	33	6.0
TOTALS	555	100.0

9. Do you find Vocational Rehabilitation counselors receptive to your referrals?		
Very	253	45.6
Fairly	128	23.1
Indifferent	11	2.0
Other	12	2.1
Not given	151	27.2
TOTALS	555	100.0

10. Has the Vocational Rehabilitation Agency ever asked you for referrals?		
Yes	210	37.8
No	292	52.6
Not given	53	9.6
TOTALS	555	100.0

SELECTED COMMENTS

11. List any specific problems you have personally encountered in referring clients to Vocational Rehabilitation.

"Services of counselor are not available except for one or two days monthly which causes hardship especially in emergency conditions"

"Complete lack of knowledge about follow-up on referral. What happens to referral after he is referred? Methods of referral not clearly defined. How is best way for client to see VR Rep.? Is it social worker's job to make appointments for VR Rep.?"

"Feeling that some referrals end up in 'File 13'. There could be many reasons for this feeling but if communication is kept between referral agency and VR we would know what has been considered and if attempts have failed. There seem to be many instances of non-feasibility."

"Caseworkers report to me their frustration and discouragement about the many cases they refer who are rejected as 'unfeasible' for VR services. They would like VR to go into situations more deeply to encourage clients to avail themselves of the services."

"The rigors of seemingly 'ultra-officiality' have been the only problems that are prevalent to me. That is, I feel more personal warmth and insight into the individual's feelings should be educed from the counselors, rather than just being concerned about the mechanics of getting the job done."

"Not being entirely familiar with what VR can or cannot do sometimes results in my not referring a client who might have been helped."

"In some cases the person involved doesn't know why he is turned down, or just what action has been taken. This he needs to know."

"Programs limited—funds not available to incorporate more people into their programs."

12 Please describe briefly your feelings about the importance of vocational rehabilitation services for your county.

"Very important as this is one very important aspect of overall rehabilitation that we are trying to accomplish with all our patients."

"I feel VR services are very important and could perhaps be more widespread if more people in our country knew of VR and were more willing to seek their services."

"From cases I have referred I have found it has given these people a new chance for themselves as well as their family. Of course, the patient has a lot to do with whether maximum benefits can be attained."

"One of this agency's principal resources"

"Financially inadequate. Can't handle number in need."

"Vocational Rehabilitation has possibilities of being one of the agencies most valuable to this community."

"Could be very helpful if their handcuff were taken off."

"I feel it is important and has taken on new dimensions since counselors have been stationed in the county."

Very important. Need to make more people aware of services."

"Now that we know—I'd hate to be found without their help."

"VR services are important in our county, but expansion of services is needed as well as expedition of recommendations."

"I feel much could be done to improve the service. Vocational rehabilitation is important for any country. I doubt the effectiveness of the program to reach a major portion of all people who are in need of their service."

"an invaluable aid"

13. What do you see as the primary problems of communication, coordination and cooperation between your agency and other social agencies concerned with providing services to people in need?

“Lack of real concern for the well being of our clients”

“Primary problem is not being familiar enough w/ the other agencies and their services and thus perhaps steering our clients in the wrong direction—perhaps referring them for a job that is not available or suitable for this person”

“Need for more time to be spent in the county by V. R. counselor so as to be more accessible. This would help solve the problems of communication, coordination, and follow-up contacts regarding a client referred.”

“Each agency program has developed certain guidelines for operation—having definite goals etc.—There is a tendency to become so ‘self contained’ in our operations that we fail to see how other agency operations will correlate”

“Coordination of effort is the important and necessary ingredient to make a system of this type work. There needs to be a greater amount of cooperative effort exercised between all agencies in

the county serving the needs of these people.”

“Everybody seems to want to pass the problem to the next agency—”

“A higher frequency in inter-agency conferences would greatly enhance communication and coordination. I believe that each agency is willing to cooperate within the bounds of their rules and regulations. All social agencies have designated functions and responsibilities, with an equal amount of rules and regulations. We should commit ourselves to understanding more about each other and the role of each agency and then decide how we can cooperate to complement each other and provide a well-rounded program of total services to all.”

“There has been excellent cooperation between our agency and other social agencies; However I believe that: (1) There are too many agencies providing the same or similar services; (2) Agencies’ differing policies concerning payment of medical personnel for services rendered should be brought into harmony (3) Additional interagency communication and planning would result in meeting the needs of more people; (4) Appointment of a county interagency coordinator would bring about even further communication, coordination, and cooperation among all agencies in our county.

CONCLUSIONS

It is evident from this Interagency Relationship Survey as well as from nearly every other activity initiated by the North Carolina Study in Vocational Rehabilitation that the Vocational Rehabilitation Agency has done an inadequate job of disseminating information about its services to other agencies and that there are some inequities regarding the provision of services to some geographic areas in the state. Sixty-nine per cent of the persons interviewed in the randomly selected counties did indicate that vocational rehabilitation had supplied them with information concerning its service. However, upon probing, it was revealed that some of the respondents had only bits of information which they had obtained by directing specific questions to a vocational rehabilitation counselor.

Another conclusion, which in some ways is surprising, is that there appears to be massive misconceptions of the word "disabled". Forty-six per cent of all the agency respondents indicated that they worked with no more than five disabled persons monthly. Apparently this is a woefully conservative figure since in Vocational Rehabilitation's terminology, disability includes anyone with limiting mental, physical and emotional conditions as well as the educationally, socially and culturally deprived.

Question three illustrates with conclusive evidence that at least two-thirds of the professional workers responding to the survey considered their office *very* accessible to their clientele. The fact is, that many of the offices are located in areas which are difficult to reach even if a person has a vehicle and they are impossible to reach if no car is available to the person in need. There are very few offices that are accessible to severely disabled persons (i.e. those in wheelchairs or restrictive braces).

A final conclusion may be that (refer to question four) two of our long established "agencies"; public schools and the Employment Security Commission, were chosen far too few times by respondents from other agencies since these two agencies should be especially dealing with the general area of disability and/or preparation for the future. It must be mentioned, however, that some people do not refer to public schools as an agency; this is a mistake which should be corrected. The Employment Security Commission is not mistaken by anyone, however, as being a "non-agency".

RECOMMENDATIONS

1. IT IS RECOMMENDED THAT COMMUNITY COORDINATING COUNCILS OR SOME OTHER ACTIVITY GROUP NEEDS TO BE CREATED TO FULLY AND EFFECTIVELY UTILIZE PRESENTLY AVAILABLE RESOURCES. As a direct result of this study two of the participating counties have begun agency coordinating councils as a means of narrowing the gaps that exist between them.
2. ANOTHER RECOMMENDATION IS THAT THE VOCATIONAL REHABILITATION AGENCY SHOULD INITIATE AND CREATE A FORMALIZED PROCEDURE FOR FOLLOW-UP WITH EACH AND EVERY CLIENT REFERRED TO THEM. FURTHER, THE AGENCY SHOULD ASSUME THE RESPONSIBILITY FOR REPORTING IN WRITING ITS DISPOSITION OF REFERRAL TO THE REFERRING AGENCY.
3. AS A RESULT OF THIS STUDY, IT IS A NATURAL RECOMMENDATION THAT VOCATIONAL REHABILITATION COUNSELORS ENGAGE THEMSELVES MORE FULLY IN COUNSELING AND GUIDANCE ACTIVITIES. The interviews pointed out that many counselors have become technicians and that if they can offer nothing to a disabled person in the way of surgery, appliances, tools or training, they conclude that they have no services to offer. While it may be true that many counselors are not well trained in counseling, training in counseling methods should be the number one priority item in any pre-service or in-service training program.

SAMPLE SURVEY

Workshop and Vocational Rehabilitation Clients

Two district offices and four sheltered workshops were asked to pick as randomly as possible from their files several "closed" cases and to find out how these former clients are now doing in their employment. The reason for this request was to show the dramatic black-and-white figures on the economic worth of rehabilitation. It is realized that rehabilitation involves much more than dollars and cents, but many people want to know where their tax dollar goes and they deserve to know.

The following figures have been prepared as accurately as possible. What has been done, in short, is to take each worker's *present* salary and project this figure up to retirement age, although it is realized that each worker may not work to age 65. There was no allowance for any pay increases. For the tax figure, the very minimal tax figure of 14 per cent total for State and Federal taxes was used.

Number of Clients	88
Average Age	30
Average Weekly Wage	\$61.36
Average Years Employment Remaining	35
Rehabilitation Cost Per Client	\$824.79
Total Rehabilitation Cost	\$72,581.78
1 Years Wages	\$280,761
35 Years Wages	\$9,826,635
Taxes	\$1,375,728.90

NOTE: No sales tax was accounted for although it was estimated that each person would pay 3% sales tax on at least \$40 weekly which would give a 35 year total for 88 clients of \$192,192.

NOTE: At the rate of approximately \$1,500 per year per person, it would cost \$4,620,000 to institutionalize or support the 88 with public assistance.

Results

Discounting sales tax which would more than likely be paid anyway except in the unpredictable event of institutionalization, but supposing an average welfare support for Aid to the Permanently and Totally Disabled of \$50 per month which would amount to \$1,848,000, these figures illustrate that *good* (lasting) vocational rehabilitation can pay as much as a \$44 return on every \$1 invested. Although these figures came from a very small sample and were not put into a complicated formula, they are not too far out of line with top estimates. National estimates on the cost-benefit ratio for vocational rehabilitation ranges from \$16:\$1 to 35:\$1.¹ The discrepancy probably is directly related to the completeness of rehabilitation services rendered. The profit in correcting acute problems is probably negative or at best negligible if chronic problems are not recognized and dealt with effectively. This is illustrated by the data on pages 243-257.

¹Human Investment Programs. Vocational Rehabilitation, 1967: Program Analysis. U. S. Department of Health, Education and Welfare, Office of Assistant Secretary (Planning and Evaluation), December, 1967.

Recommendation

The Governor's Study Committee on Vocational Rehabilitation respectfully submits the following recommendation:

The State of North Carolina should appropriate and/or secure sufficient financial resources from its general tax fund, the Rehabilitation Services Administration of the Social and Rehabilitation Services, Department of Health, Education and Welfare, and local governments to establish offices of the Division of Vocational Rehabilitation in every county with a population of 30,000 or more. Such action would require a professional field staff of 165 general vocational rehabilitation counselors and the establishment of additional offices.

The reason for this recommendation is that an inter-agency relationship study revealed that one of the main problems in communication, coordination and cooperation was the geographical separation between vocational rehabilitation personnel and other county based service programs. In addition to providing the means for more effective inter-agency efforts, the vocational rehabilitation personnel will have an opportunity to become better acquainted with the professional resources in his client's community and also with the business and industrial structure of the community. Such information and knowledge is vitally important if the counselor is to provide a meaningful and quality service to his disabled clients.

The estimated cost of this recommended expansion would be:

	40 Additional Offices	
1. Professional Personnel	(92 Counselors)	\$703,800.00
2. Support Personnel	(40 Stenographers)	230,506.00
3. Office Equipment and Supplies		74,050.00
4. Office Rent		69,000.00
		\$1,077,336.00
State Share		269,334.00

SUMMARY OF WORKSHOP STUDIES

WORKSHOP STUDY

Largely as the result of the 1965 amendments to the Vocational Rehabilitation Act there was a fantastic growth and development of new sheltered workshops in the state of North Carolina. In 1965 there were only three sheltered workshops located in the state. Today there are 34 workshops scattered across the state in varied communities. (For locations see map on page 204) Most of the sheltered workshops with the exception of three Goodwill Industries are oriented almost exclusively toward serving the mentally retarded.

In addition to the legislation which made the development of community workshops possible there was a simultaneous reorientation of the state's Mental Health Department. The institutions for the mentally ill and the mentally retarded were being transformed from basic custodial facilities into active treatment centers with the goal of moving their patients back into the community as rapidly as possible. These two factors contributed to the aforementioned state agency aggressively encouraging community groups and organizations to establish facilities in the community which would prevent the necessity of admitting any but the most acutely ill or retarded individuals to residential facilities. The communities accepted this encouragement much more rapidly than was anticipated and developed sheltered workshops or plans for the same at a rapid rate. This explosion of development caught the agencies by surprise and made it quite difficult for them to slow the growth of these resources in keeping with their available budgets. When the agencies found themselves in financial difficulties and unable to support the workshops to the extent expected by the community there was a huge cry for relief which could be heard from all parts of the state regarding the unmet needs of sheltered workshops. This situation called the attention of the North Carolina Study to sheltered workshops. Subsequently, requests were made for caseload and follow-up information regarding clients being served in the workshops and those who had been placed in employment after workshop training. (Included on page 197.)

Through visits with workshop people it was learned that they were not only distressed by their financial crisis but also were feeling quite anxious about selling such things as *vocational evaluation*, and *personal* and *social adjustment training* services to the Rehabilitation Agency because they were not sure of what they were doing. There appeared to be no standardized evaluation procedures and personal and social adjustment training was not well structured.

The workshops felt the need for leadership in developing some skills and techniques for accomplishing evaluation and personal and social adjustment training.

There also was considerable consternation on the part of workshop directors concerning the rehabilitation counselors who had been assigned to their workshops. Job descriptions for these positions were drawn up hurriedly and were being interpreted to mean different things by different individuals. The workshop counselor was in a precarious position because he was not sure what he should be doing.

Members of the North Carolina Study staff met with members of the executive committee of the North Carolina Workshops Association and suggested they take some positive action rather than waiting for someone else to solve their conflicts. It was suggested that the workshop directors conceptualize for themselves the way in which a vocational rehabilitation counselor could be of most use to the workshop and present these recommendations to the Agency for consideration.

Through contacts with the workshops there was an attempt to determine if there are ways to reduce the administrative cost of sheltered workshops. This effort resulted from the finding that it costs the Vocational Rehabilitation Agency for personal and social adjustment training, vocational evaluation, vocational training and transportation, 240 percent more than it costs to keep a student in the North

Carolina public school system. Inquiries regarding reasons for the discrepancy in cost have resulted in the conclusion that the primary reason for the difference is that schools traditionally serve a more dense population and school units are larger. The question has thus arisen, and it is hoped that proper authorities within the state will evaluate the advantages of developing consolidated workshops that will serve larger regions than are presently served by the small workshops. Another idea that is being fostered is that the Rehabilitation Agency, the Department of Mental Health and workshop employees begin taking a very close look at present programs, analyzing them on a cost-benefit basis, search for the specific elements in the workshop experience that are beneficial to clients; thereby eliminating the activities with only an assumed value.

Subsequent study of the workshop situation in the state led to the following findings:

1. The financial condition of the Vocational Rehabilitation Agency has resulted in a client quota assigned to sheltered workshops without regard to their capacity for service.
2. The client quota was established on the basis of case service funds in the agency's budget. Very few of the workshops presently are serving their assigned quota (19).
3. No excuses are given for the fact that full client quotas are not being served in workshops at this time. Information from the agency indicates that workshops could be utilized to full capacity by *present counseling staff* if sufficient funds were available. There is insufficient information to account for the present failure to fully utilize the established quotas.*
4. There is ample research data to indicate there *should not* be a lack of vocational rehabilitation clients to fill a properly operated sheltered workshop.
5. There are plenty of mental health subsidy cases (Terminal Type) desiring workshop services but the mental health agency is also lacking the necessary funds to meet the full need.
6. Many of the sheltered workshops are serving low producing persons for whom they receive no reimbursement. Such services are expensive in light of the small margin of profit realized by workshop operations.
7. The workshops desire to maintain a rehabilitation orientation but to do so under present conditions is becoming more and more difficult.

Observations of the North Carolina Study Staff, discussions with Vocational Rehabilitation Agency personnel, workshop directors, Department of Mental Health personnel, and members of the Study's Single Disability Task Forces indicate the following needs if a better sheltered workshop system is to be developed for the state:

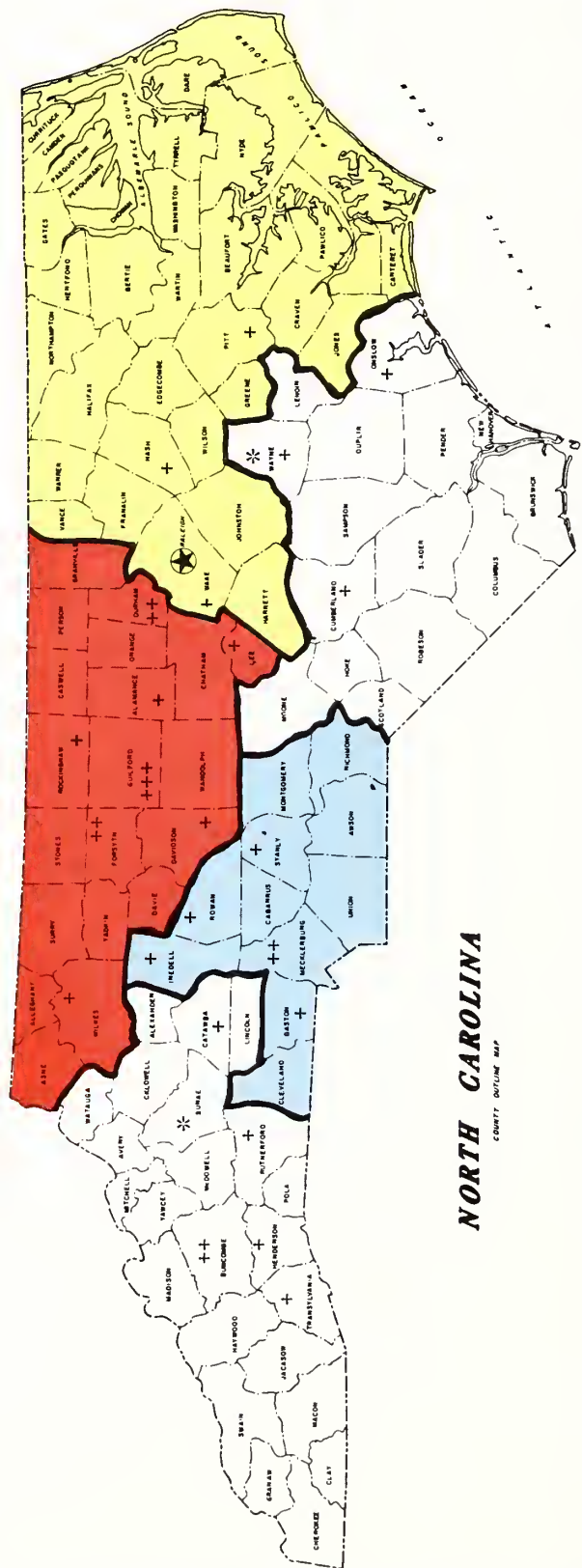
1. Personnel in sheltered workshops should be provided intensive *in-service training*. There are many community colleges, universities, technical institutes, short-term training programs, and other agencies with the potential of providing needed training if they were assisted in developing programs for this purpose.
2. There is a growing need for *live-in facilities* to be developed in conjunction with workshops. Transportation is an ever increasing problem which a dormitory or boarding house facility properly managed would alleviate. Such facilities would allow for the development of regional shops in lieu of the presently small community shops whose administrative costs should be decreased if they can be enlarged.
3. More *technical assistance* should be made available to the workshops. The Division of Vocational Rehabilitation, by establishing a state workshop co-ordinator with a staff of six field consultants is attempting to provide this assistance. Personnel for these positions must be *trained and developed* if they are to be of any appreciable help to the sheltered workshops.
4. Workshops need to become more *production oriented*. Work adjustment by working and producing is the most important service which a workshop can provide. (See p. 205 for additional rationale).

*Private conversations with rehabilitation counselors indicate that there are some who question the value of training provided in sheltered workshops. Correspondence received in this office confirms that this attitude does exist in some places. The attitude may be valid but even if it is, it seems that the Agency should assume responsibility for helping the workshop develop an adequate program rather than withholding its referrals.

RECOMMENDATIONS

1. It is recommended that the Division of Vocational Rehabilitation, Department of Mental Health, and local communities work together toward the planning and establishment of *live-in facilities* for workshop clients.
2. Workshops need to develop a *broader scope* that will benefit all types of disabilities, not only the mentally retarded. *All* physical and mental disabilities need to be served and, until they are, we can not lay claim to comprehensive sheltered workshops.
3. The Vocational Rehabilitation Agency should provide more technical assistance. It is thought that the recent proposal for a statewide co-ordinator and six field consultants will meet this need but, as stressed earlier, we must *adequately train* these individuals.
4. Another recommendation is that *all* counselors should refer clients to the workshop, not just the so-called workshop counselors. Members of the North Carolina Study Staff saw this in operation in another state and indications are that this is an ideal situation. Involvement of all personnel seems to give a better understanding of workshops and vocational rehabilitation's use of them as service facilities.
5. It is recommended that the workshops concentrate on the value of actual *work experience*. The workshops are developed for the purpose of helping the disabled reach their optimal position. Social experience and other educational factors are important, but main stress should be placed on work.

Figure 13.



- + community workshop
- * institute workshop

APPENDIX VI

Professional people who work with the mentally retarded speak very freely of the importance of personal and social adjustment in the rehabilitation process of the retarded. Importance is also attached to the achievement of personal and social adjustment with other seriously or chronically handicapped individuals. Employers and personnel directors agree with the concept of the "helping professionals" that personal and social adjustment is of prime importance if an individual is ever to be successfully employed and satisfactorily adjusted to community living. There is no doubt as to the validity of these ideas.

Although this subject creates a great amount of conversation, there has been very little written regarding the techniques of developing personal and social adjustment within an individual. What has been written and what is practiced has been almost purely pragmatic and has not been sufficiently researched. Designing research in this area would be extremely difficult since personal and social adjustment programs are not based on any concepts nor is there a basic philosophy or philosophies with premises which can be tested.

With the blessings and strong encouragement of the Vocational Rehabilitation Agency, sheltered workshops have placed a tremendous amount of emphasis on the provision of personal and social adjustment training. It is felt that present methods of operations need to be very critically analyzed with regard to their effectiveness. This is only one area of research being recommended for sheltered workshop programs.

In the absence of a concept upon which personal and social adjustment training can be developed the following ideas are offered.

What is personal and social adjustment and what does it mean? Personal and social adjustment is behavior that is acceptable to one's social situation. Social adjustment is dependent upon personal adjustment. Unacceptable social behavior and relationships are prompted by poor personal adjustment. An individual with satisfactory personal adjustment (which implies an appreciation of one's self as a worthwhile person) is not going to find himself involved in social conflict or in the position of rejecting legitimate social expectations.

Supposing that the above premise is true it would seem that personal and social adjustment hinges on a satisfactory self concept. Elemental theories of psychology indicate that the development of a satisfactory self-concept is dependent upon having had satisfying inter-personal relations with important people during a person's early life (parents, siblings, teachers, etc.). If the individual has been denied such experiences and develops a negative "self-image" quite early in life, there is a tendency for this concept to grow larger, more complex and more debilitating with age. As contacts are established with broadened social horizons, he is naturally going to face the world with distrust, hostility, and no feelings that cooperativeness is important. An understanding of developmental psychology also indicates that such problems cannot be ameliorated by a rational approach since such feelings have an emotional rather than a logical basis.

If the above were not true there would have been no necessity for the development of counseling techniques, psychotherapy, or psychoanalysis. Neither would the pharmaceutical companies have such a large market for tranquilizing drugs.

A severely bashful person can never overcome the problem of bashfulness regardless of how often his friends or associates assure him that there is no reason for his feelings of insecurity around strangers. Before the problem can be overcome the person must *develop* a new self-concept which includes the acceptance of himself as an individual with traits and a personality acceptable to others.

Personal and social adjustment cannot be achieved in a structured classroom setting. The pragmatic, logical, pyramiding curriculum approach to the development of acceptable social traits is doomed to failure. There is no doubt that so long as a person is enrolled in such a program his behavior may change and that this change will continue so long as there is some person as important as the instructor who will continue to challenge and reward him for positive behavior such as personal cleanliness, politeness, promptness, perseverance, and the ability to avoid peer conflicts. However,

unless such encouragement and instruction is given, the desired behavior will diminish and finally disappear because the client's self-concept has not been restructured thoroughly enough to make the desired behavior personally gratifying.

To give a concrete illustration of the above, the following example is cited. A child is born into an average middle class home. Cleanliness is a virtue and usually the child will enjoy bathing so long as this experience entails receiving the full attention of a parent during the bath. The parental attention is pleasing to the child and if it is undivided, the process is quite satisfying and is approached with gleeful anticipation. However, when the child becomes old enough so that bathing is a personal matter which does not include satisfying attention from another person the experience loses its appeal. By the time the child has reached this age he does not place any *personal* importance on cleanliness and usually rebels to some degree about having to bathe. The child will bathe only as the result of constant reminders or demands from his parents to do so. Usually this bathing process is never accomplished as a result of personal volition until cleanliness becomes personally meaningful. This generally occurs at adolescence when the individual develops an interest in the opposite sex and finds that he is more acceptable in heterosexual groups when he is personally clean. The same analogy could be drawn in relation to cleanliness and orderliness of one's habitat. A habit will not be established until clean surroundings become personally meaningful.

If the concept is true that personal adjustment is a pre-requisite for, and insurance of social adjustment, then it becomes quite clear that the achievement of personal and social adjustment during a sheltered workshop experience is far more dependent on the development of satisfactory relationships with the floor supervisors and other personnel than upon classes and a structured curriculum. In fact it should be realized that no matter how simple instructions are made in the workshop classroom regarding personal hygiene, avoiding conflicts with peers, dressing appropriately, acceptable grooming, getting along with an employer, paying obligations, and saving money, these subjects are just as theoretical to the client as the "theory of relativity".

It is this concept upon which the recommendations for the workshop becoming more production oriented was made. The important relationship which can be developed during production supervision probably has far more relative and lasting value than any curriculum material that can be presented in a classroom.

There are certain adult basic education needs which many workshop clients can master and which need to be mastered if the client is to live in the community as effectively as possible. These needs would include remedial reading, further development of verbal skills, and the mastery of simple arithmetic needed to keep a bank account, pay bills, etc.. These are subjects for which adult education programs are specifically designed and which can be best taught by professional adult educators. There are research findings which indicate that involvement in evening Adult Education programs give workshop clients a feeling of prestige which further enhances the development of their full potentials. It would seem that workshops are making a serious mistake if they are attempting to provide such services prior to exhausting all other potential educational resources which might be available to their clients.

COORDINATION WITH OTHER STATE PLANNING GROUPS

COORDINATION WITH OTHER STATE PLANNING

Although the North Carolina Study in Vocational Rehabilitation has had contact with many of the state's other planning organizations, there has been very little joint planning per se. A number of contacts for both general and specific discussions have been held with the:

1. Regional Medical Program on Heart, Cancer and Stroke
2. The Governor's Blue Ribbon Study Committee on Education
3. The North Carolina Council on Mental Retardation
4. The North Carolina Mental Health Planning Staff
5. The Staff of the Comprehensive Health Planning Program
6. The Coordinators of Model Cities Planning (Charlotte, Durham)
7. Representatives of Both State and Local CAMPS Committees
8. Local Technical Action Panels
9. CEP Planners

The essence of the conclusions reached during these numerous meetings is that the plans being formulated by each individual group are contingent upon the coordination and cooperation of all state and private social service programs. Further, the discussions have revealed that the main concerns of all the various groups are those of insufficient professional and technical manpower, a shortage of facilities and inadequate utilization of present resources and the difficulty in coordination of service programs, many of which are overlapping and hardly distinguishable from one another except for minor points in general orientation.

A difficulty which has been discovered through these contacts is that there are a number of programs being planned specifically for the culturally and socially deprived which profess a need for coordinating their efforts with existing resources but who have implied that there are moneys available in their program to do the complete job of case findings, comprehensive diagnosis, medical and psychological services, counseling and guidance, vocational training and placement, follow-up and continuing health care supervision. If these conditions exist, it is tremendously difficult to understand why there is talk of needing to coordinate their programs with existing programs and there is frustration in trying to define areas where coordination and cooperation is possible. Another difficulty encountered is that many of the aforementioned programs are having difficulty in performing their assigned functions because these functions are so nebulous and their efforts so generalized that it is difficult to get real community involvement or interagency participation primarily due to a lack of understanding regarding the purpose of the organization. As was mentioned quite early in this report, the North Carolina Study in Vocational Rehabilitation has also encountered many identical difficulties to the one just described.

It is the feeling of the North Carolina Study staff that the CAMPS program has a tremendous potential for helping develop the state's social service system into one that is most effective and highly efficient. However, it is further believed that if these positive gains are to be realized, some real authority must be given CAMPS or some other similar group with a closer affiliation with the state's Department of Administration.

STUDY OF THE ADMINISTRATION OF VOCATIONAL REHABILITATION PROGRAMS IN THE STATE

**Analysis of State Agency Data and
Characteristics of Agency Personnel and Caseload Practices**

Report of Counselor Caseload Practice Survey

**Discussion of the Administrative Location
of the State Vocational Rehabilitation Agency**

**A Report on the Work of the
Architectural Barrier's Subcommittee of the
Governor's Study Committee**

**A Report of Efforts to Bring Vocational
Rehabilitation to the Attention of
Candidates for Public Office**

A Report on Transportation Problems

MANAGERIAL DATA
VOCATIONAL REHABILITATION AGENCY:
A Statistical Analysis of Program, Practices
And Professional Personnel in North Carolina
1966-1967

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MANAGERIAL DATA
VOCATIONAL REHABILITATION AGENCY:
A STATISTICAL ANALYSIS OF PROGRAM, PRACTICES
AND PROFESSIONAL PERSONNEL IN NORTH CAROLINA
1966-1967*

With the continuing expansion of vocational rehabilitation programs at both the federal and state levels, state organizations become increasingly complex. This increasing complexity results in fewer opportunities for face to face interaction among staff members at different levels. Local counselors become separated by several echelons from administrative personnel at the state level. Increase in personnel should result in better services for the client, but evaluative procedures can no longer remain relatively informal and unstructured if objectives are to be achieved. Policy making, program planning, decisions about priorities of effort, as well as modifications and adaptations in current procedures must increasingly be based on a viable, on-going research program.

Research staff members must have the capacity and background to design research programs that meet practical agency needs, coordinate agency and academically based programs, interpret agency research demands to interested academic professionals and present research findings in a form that can be used by the rest of the agency staff at appropriate levels. There should be sufficient flexibility and adequate staff so that procedures employed in data accumulation use a minimum of available counselor time that should be devoted to client oriented activities rather than agency accounting practices.

It is essential in an investigation of agency functioning to begin by utilizing primary resource material. This prevents wasteful duplication of effort and allows maximum efficiency in research effort. It allows for evaluation of routine reporting procedures and makes possible modifications and adjustments so that maximum information is continually available. The research programming can then be oriented toward seeking new information from unexploited sources and validating existing sources where questions have arisen. Field research can then be of greater value, since it will be based on an understanding of existing policies and procedures. Recommendations based on this type of research can be of practical value to those seeking to strengthen and modify agency functioning.

The analysis in the following pages is based primarily on accumulated information available from state agency files. It is illustrative of the kind of research that is possible utilizing existing records which continually flow into the central office from local district offices. Through this analysis a picture of state agency operation can be gained. While comparisons between North Carolina averages and the national averages are presented, such comparisons, though interesting, are of limited usefulness in evaluating the effectiveness of efforts throughout a state as complex as North Carolina. For this reason, tables have been constructed illustrating comparative rates for various categories among counties, districts, areas and regions.

*Data for this report are based on the records of the North Carolina Division of Vocational Rehabilitation, Department of Public Instruction. Information was initially obtained in rough from Central Data Processing, Department of Administration. Final statistical processing for tabular form was under the supervision of Mrs. Shirley Crowder, Research Assistant, North Carolina Study in Vocational Rehabilitation.

NORTH CAROLINA IN THE NATION

The North Carolina Division of Vocational Rehabilitation and the North Carolina State Commission for the Blind compared very favorably with the Nation as a whole during the fiscal year 1966-1967. Table 13 shows North Carolina rates of service compared with similar rates for the United States.

Table 13. Vocational Rehabilitation in the United States and North Carolina, 1966-1967

<u>Nature of Rate</u>	<u>United States</u>	<u>North Carolina</u>
Average number of active cases served per employee man-year	43	72
Average number rehabilitated per employee man-year	13	34
Number served per 100,000 population	287	417
Number rehabilitated per 100,000 population	87	191
Number of persons rehabilitated by agencies for the blind, per 100,000 population	5	11

Source: **Caseload Statistics, State Vocational Rehabilitation Agencies—Fiscal Year 1967.** U. S. Department of Health, Education and Welfare, Social and Rehabilitation Service, RSA, Division of Statistics and Studies, Washington, D. C. 1967.

Some of the above rates are two to three times greater for North Carolina than for the United States. Table 14 shows the distribution of persons by age at time of referral for both the United States and North Carolina. Except for the slightly larger percentage of cases under twenty years of age for the United States, North Carolina follows closely the national pattern in respect to the age distribution of its clients. These relationships are expressed graphically in Figure 14.

From the foregoing it can be concluded that services in North Carolina were generally broader than those for the Nation as a whole. No attempt has been made in this analysis to compare North Carolina with other states because the chief purpose here is to study *internal* variations in services. The comparison with national averages should not imply that real needs were met completely either in North Carolina or in the rest of the country. Adequacy of programs can only be assessed on the basis of information about prevalence of potentially rehabilitable disabled persons in a given population, and accurate data on this are not available for either the state or the nation.

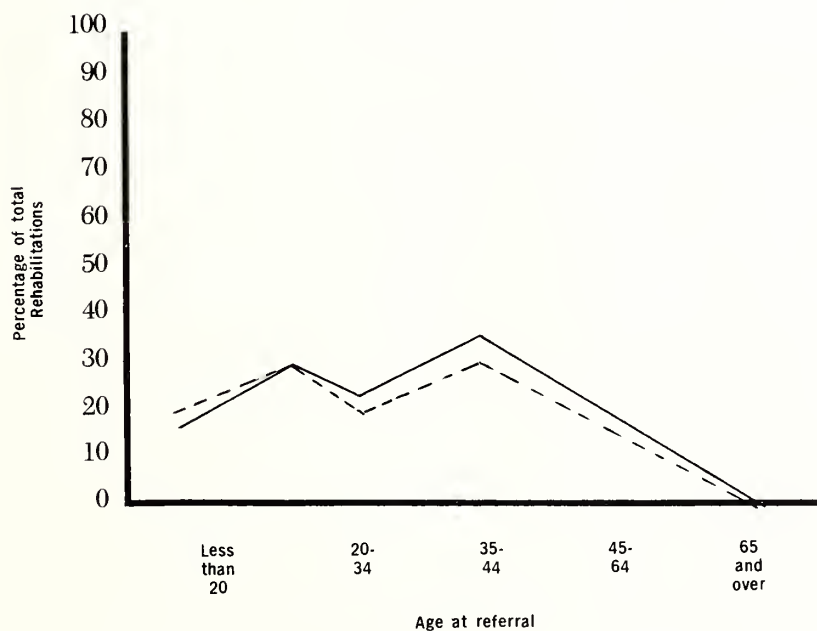
Table 14. Age at Referral of Persons Rehabilitated in the United States and in North Carolina, 1966-1967

Age of Referral	Percentage of Total Rehabilitations <u>United States</u>	<u>North Carolina</u>
Less than 20 years	22.6	16.1
20-34 years	30.8	30.0
35-44 years	19.0	22.8
45-64 years	25.2	29.9
65 years and over	1.8	1.2
Not reported	0.6	0.0
	100.0	100.0

Sources: 1. **Characteristics and Trends of Clients Rehabilitated in Fiscal Years 1963-1967.** U. S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, Rehabilitation Services Administration, Division of Statistics and Studies, Washington, D. C., Table 3, p. 10.
2. Records of the North Carolina Division of Vocational Rehabilitation.

From Table 14, on preceding page, and Figure 14 which follows, it can be seen that the age distribution of North Carolina referrals is quite similar to that for the nation as a whole. There is a slight difference between the proportion of referrals below the age of twenty who were rehabilitated in this state as compared to the national average.

Figure 14. Age at Referral of Persons Rehabilitated in the United States and North Carolina, 1966-1967



REHABILITATION SERVICE IN THE STATE

Disposition of cases coming to the attention of rehabilitation counselors varies with the age at the time of referral. In Table 15 below can be seen the numbers and percentages of cases closed from referral, closed as not rehabilitated and closed as rehabilitated at each age level.

**Table 15. Age at Referral of Vocational Rehabilitation Clients, by
Status of Client: North Carolina, 1967**

<u>Age at Referral</u>	<u>Closed from Referral</u>	<u>Closed not Rehabilitated</u>	<u>Closed Rehabilitated</u>	<u>Total</u>
Less than 20	2015 (33.6%)	108 (15.6%)	1449 (16.1%)	3572 (22.8%)
20-34	1337 (22.3%)	199 (28.6%)	2696 (30.0%)	4232 (26.9%)
35-44	924 (15.4%)	144 (20.7%)	2051 (22.8%)	3119 (19.9%)
45-64	1633 (27.2%)	231 (33.2%)	2687 (29.9%)	4551 (29.0%)
65 and over	81 (1.3%)	12 (1.7%)	111 (1.2%)	204 (1.3%)
Not reported	9 (0.2%)	1 (0.2%)	4 (0.0%)	14 (0.1%)
Total	5999 (100.0%)	695 (100.0%)	8998 (100.0%)	15692 (100.0%)

Source: Records of the North Carolina Division of Vocational Rehabilitation, tabulations by Central Data Processing.

It is interesting to note that while a sizeable number of clients below twenty were referred to the agency (approximately 23% of all referrals), this group represented only sixteen percent of those rehabilitated. A third of the cases closed from referral were from this younger group. Less than one third of those referred in this age category were successfully rehabilitated before the cases were closed. Why this group of clients are not or cannot be served effectively is not known, but if these young disabled people are not reopened for services later, it can be assumed that many of them will necessarily remain in a state of economic and social dependency for many years. One area that seems to demand more analysis is the service available for younger clients.

From the columns headed "Closed not Rehabilitated" and "Closed Rehabilitated", it can be noted that possibly a somewhat disproportionate number of clients between twenty and forty-five received services. It is apparent that the likelihood of receiving agency attention is probably greater in these age ranges. Older clients are represented among those receiving services in numbers proportionate with the number of referrals. Younger clients are presumably receiving a lesser share of counselor and agency time.

Restrictions on types of services that may be rendered limits the opportunities for older clients. If the definitions of services eventually expands to include such functions as developing self-care skills, etc. which will render older persons less physically dependent on others if not economically self-sustaining, clients in the older age brackets may increase. The form of service to older people can, in many cases, release a younger worker for paid productive employment.

Sex

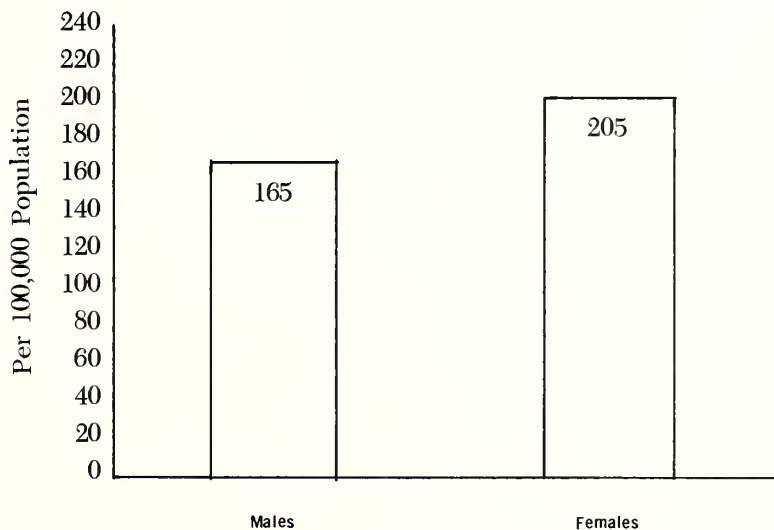
The sex distribution of referrals and their ultimate disposition can be observed in Table 16. There is a relatively small difference in the number of males and females referred to the agency. Overall, however, more females than males were closed as rehabilitated. Among males a higher percentage were closed from referral or given services but not successfully placed before closure. This greater preponderance of females in the rehabilitated group can be seen graphically in Figure 15 which indicates that per 100,000 females, 205 were rehabilitated as compared to 165 males per 100,000.

Table 16. Sex of Vocational Rehabilitation Clients, by Status of Client: North Carolina, 1967

<u>Sex</u>	<u>Closed from Referral</u>		<u>Closed not Rehabilitated</u>		<u>Closed Rehabilitated</u>		<u>Total</u>	
Male	3309	(55.2%)	409	(58.8%)	3919	(43.6%)	7637	(48.7%)
Female	2690	(44.8%)	286	(41.2%)	5079	(56.4%)	8055	(51.3%)
Total	5999	(100.0%)	695	(100.0%)	8998	(100.0%)	15692	(100.0%)

Source: Records of the North Carolina Division of Vocational Rehabilitation, tabulations by Central Data Processing.

Figure 15. Rates Per 100,000 Population*, by Sex of Person Rehabilitated, North Carolina, 1967



*Number of Males per 100,000 males and number of females per 100,000 females in the general population, U. S. Census of Population, 1960.

Later in the paper, the ultimate occupational placement of rehabilitation cases will clarify the reason more women than men are in the rehabilitated category. Almost one fourth of this category consists of homemakers. This is unquestionably an important and valid placement for many women. The assumption can be made that men are more likely to be placed in productive employment when they are closed as rehabilitated. This requires more counselor time and skill, and it can be assumed this is why more women are successfully rehabilitated.

Race

For two categories, "Closed not rehabilitated" and "Closed rehabilitated," information was categorized by race. Race was not reported for approximately 6000 cases which were closed from referral. For this reason it is difficult to draw any conclusions about the equality of services among racial groups in the population. In Table 17 below it can be noted that approximately 40% of all referrals were from the white population and 22% from the nonwhite (principally Negroes and Indians in this state). Among those closed as rehabilitated approximately 64% were white and 36% nonwhite.

**Table 17. Race of Vocational Rehabilitation Clients, by
Status of Client North Carolina, 1967**

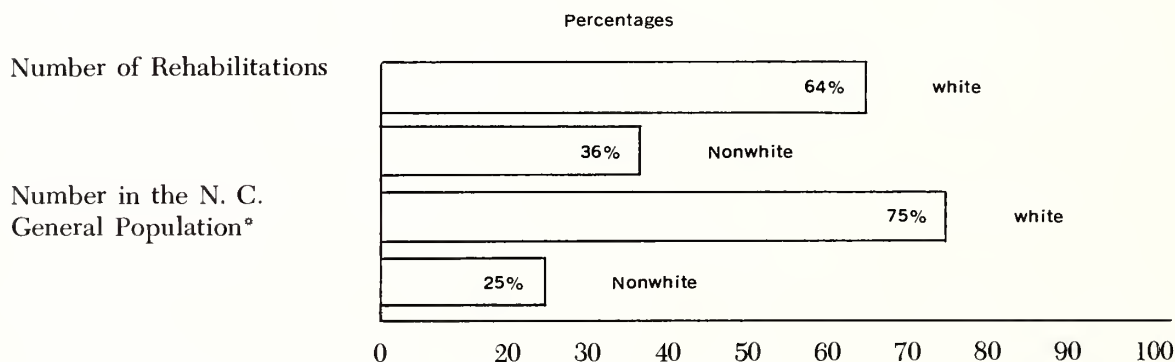
Race	Closed not Rehabilitated		Closed Rehabilitated		Total	Percent of total referrals
White	472	(67.9%)	5730	(63.7%)	6202	39.5
Nonwhite	220	(31.7%)	3230	(35.9%)	3450	22.0
Not reported	3	(0.4%)	38	(0.4%)	41	38.5*
Total	695	(100.0%)	8998	(100.0%)	9693	

*These percentages are based on the total of 15,692 referrals which includes 5,999 closed from referral and for whom information on race is not reported.

Source: Records of the North Carolina Division of Vocational Rehabilitation, tabulations by Central Data Processing.

Figure 16 illustrates the comparison of rehabilitations by race with the percentage of white and nonwhites in the general population of the state. Nonwhites constituted 36% of the rehabilitated cases for North Carolina but represent only 25% of the general population. This would indicate that the rehabilitation agency is making an effort to meet the needs of the more economically deprived group when they are accepted for services.

**Figure 16. Race of Rehabilitated Clients and Percentages of Whites and Nonwhites
in the General Population, North Carolina, 1960**



*United States Census of Population, 1960

To state that nonwhites are adequately rehabilitated would require scrutiny of the nature of the placements. In North Carolina it is possible to hazard a guess that many low income agricultural and service jobs constitute final employment. Fifty-six percent of last year's placements were in jobs paying wages below the poverty level (\$3,000 a year).

Education

An important factor in the nature of services that can be made available as well as the ultimate status of the rehabilitation itself is the prior education of the client. A high percentage of cases referred to the counselors had less than a high school educational level, and more than a fourth of all those served did not reach the ninth grade. The educational level was not reported for the 5,999 cases which were closed from referral.

Very few of the cases who were given services had been in special educational programs during this period. Special efforts are being made to reach individuals previously diagnosed as being mentally retarded, but in the public school system many of these are not functioning in so-called special education classes. It is doubtful that more than a few cases from other types of special education programs such as those for orthopedically impaired, speech and hearing disordered, visually impaired, etc. are represented in this category, since there are a very limited number of these classes in the public schools of the state.

**Table 18. Education at Acceptance of Vocational Rehabilitation Clients,
By Status of Client, North Carolina, 1967**

<u>Number Years School Completed</u>	<u>Closed not Rehabilitated</u>		<u>Closed Rehabilitated</u>		<u>Total</u>	<u>Percentage of Total Referrals</u>
None	20	(2.9%)	251	(2.8%)	271	1.7
1-7	266	(38.3%)	3281	(36.5%)	3547	22.6
8	84	(12.1%)	1005	(11.2%)	1089	7.0
9-11	165	(23.8%)	2170	(24.1%)	2335	14.9
12	117	(16.8%)	1771	(19.6%)	1888	12.0
13-15	19	(2.7%)	250	(2.8%)	269	1.7
16+	7	(1.0.)	81	(0.9%)	88	.6
Special Educ.	3	(0.4%)	61	(0.7%)	64	.4
Not reported	14	(2.0%)	128	(1.4%)	142	39.1
Total	695	(100.0%)	8998	(100.0%)	9693	100.0

*Based on 15,692 cases including 5999 closed from referral.

Source: Records of the North Carolina Division of Vocational Rehabilitation, tabulations by Central Data Processing.

Work Status

At the time they sought agency assistance, the majority of the clients were not gainfully employed, but some were already outside the home even if underemployed. Table 19 shows the number and percentages of clients by their status at the time of acceptance for services.

**Table 19. Work Status at Acceptance of Vocational Rehabilitation Clients,
By Status of Client, North Carolina, 1967**

<u>Work Status at Acceptance</u>	<u>Closed from Referral</u>	<u>Closed Rehabilitated</u>	<u>Total</u>	<u>Percentage of Total Referrals*</u>
Wage or Sal- aried Worker	50 (7.2%)	756 (8.4%)	806	5.2
Sheltered Workshop	2 (0.3%)	5 (9.1%)	7	0.0
Self-employed	5 (9.7%)	88 (1.0%)	93	0.6
State Agency- Managed Business Enterprise	1 (0.2%)	1 (0.0%)	2	0.0
Homemaker	39 (5.6%)	622 (6.9%)	661	4.2
Unpaid Family Worker	5 (0.7%)	34 (0.4%)	39	0.3
Student	61 (8.8%)	903 (10.0%)	964	6.1
Not Working	532 (76.5%)	6589 (73.2%)	7121	45.4
Not Reported				38.2°
Total	695 (100.0%)	8998 (100.0%)	9693	100.0

*Based on 15,692 referrals, including 5,999 closed from referral.

Source: Records of the North Carolina Division of Vocational Rehabilitation, tabulations by Central Data Processing.

The workshop program in North Carolina is quite small, and in the fiscal year covered by this survey was only the beginning. The workshops should function as a training station for later employment in business and industry for some clients in the future. It represented a very negligible portion of rehabilitation clients at the period studied.

After receiving training, counseling, physical restoration and other services most of those who had sought services were placed in gainful employment: in some cases this was in state managed business enterprise, workshops, or self employment. A large number of women were functioning as homemakers and a few clients were closed as unpaid family workers. Table 20 shows the distribution of rehabilitees by work status at closure.

**Table 20. Work Status of Clients at Closure,
North Carolina, 1967**

<u>Work Status</u>	<u>Number</u>	<u>Percent</u>
Wage or salaried worker	5,853	65.0
Sheltered Workshop	163	1.8
Self-employed	554	6.2
State managed business enterprise	35	0.4
Homemaker	2,139	23.8
Unpaid Family Worker	218	2.4
Not Reported	36	0.4
Total	8,998	100.0

Source: Records of North Carolina Division of Vocational Rehabilitation, tabulations by Central Data Processing.

Older women have an advantage over older men in that in many cases rehabilitation services can enable them to continue in their profession of housewife, but men in the older age ranges have more difficulty in securing employment outside the home.

A further analysis of rehabilitated clients delineates the occupations in which they were functioning at the time of closure. Service occupations and homemaking constituted the largest categories and accounted for more than fifty percent of the rehabilitations.

Table 21. Occupation of Rehabilitees at Closure, 1967

<u>Occupation</u>	<u>Number</u>	<u>Percent</u>
Professional, technical, managerial	519	5.8
Clerical and sales	831	9.2
Service	2141	23.8
Farming, fishing, forestry	778	8.6
Processing occupation	192	2.1
Machine trades	509	5.7
Bench work	491	5.5
Structural	561	6.2
Miscellaneous	435	4.8
Homemaker	2156	24.0
Sheltered Workshop	164	1.8
Unpaid family workers	220	2.4
Vending stand clerks	3	0.1
	<u>9000</u>	<u>100.0</u>

Source:
Annual Report, 1966-67, Division of Vocational Rehabilitation, State of North Carolina.

It can be seen that the total number of rehabilitations varies slightly from the figure furnished by Central Data Processing.

Relatively few persons are placed in industrial jobs after receiving services, while almost one-fourth go into service jobs. In other categories, the placements probably reflect the job opportunity picture in the state.

Sources of Referral

Physicians refer more clients than any other single source. When medical centers (hospitals, sanatorium and other health agencies) are combined with physicians, more than half of the referrals are accounted for. Surprisingly, only slightly over fifteen percent were referred by educational institutions. Since the rehabilitation agency is a part of the state education department, it seems somewhat unusual that more persons do not approach the agency from schools and colleges.

A sizeable group of clients referred themselves for services, while others were referred by welfare agencies and a variety of other sources. Table 22 presents information as to these sources.

**Table 22. Source of Referral, Vocational Rehabilitation Clients,
By Status of Client, North Carolina, 1967**

<u>Referral Source</u>	<u>Closed from Referral</u>		<u>Closed not Rehabilitated</u>		<u>Closed Rehabilitated</u>		<u>Total</u>	
Physicians	859	(14.3%)	214	(30.8%)	3026	(33.6%)	4099	(26.1%)
Hospitals & Sanatoriums	711	(11.9%)	183	(26.3%)	2153	(23.9%)	3047	(19.4%)
Educational Institutions	1513	(25.2%)	62	(8.9%)	856	(9.5%)	2431	(15.5%)
Welfare Agencies	850	(14.2%)	87	(12.5%)	742	(8.2%)	1679	(10.7%)
Self-Referred	646	(10.8%)	57	(8.2%)	782	(8.7%)	1485	(9.5%)
Individual	332	(5.5%)	19	(2.7%)	511	(5.7%)	862	(5.5%)
Other Health Agencies	211	(3.5%)	24	(3.5%)	275	(3.1%)	510	(3.2%)
Social Security	415	(6.9%)	2	(0.3%)	19	(0.2%)	436	(2.8%)
Artificial Appliance Company	85	(1.4%)	8	(1.1%)	280	(3.1%)	373	(2.4%)
Correctional Institution	38	(0.6%)	2	(0.3%)	35	(0.4%)	75	(0.5%)
Workmen's Compen- sation	19	(0.3%)	2	(0.3%)	7	(0.1%)	28	(0.2.)
Other	150	(2.5%)	13	(1.9%)	174	(1.9%)	337	(3.2%)
Not Reported	10	(0.2%)	2	(0.3%)	14	(0.2%)	26	(0.2%)
Total	<u>5999</u>	<u>(100.0%)</u>	<u>695</u>	<u>(100.0%)</u>	<u>8998</u>	<u>(100.0%)</u>	<u>15,692</u>	<u>(100.0%)</u>

Source: Records of the North Carolina Division of Vocational Rehabilitation, tabulations by Central Data Processing

Another study has indicated that less than \$1.00 per case was spent for diagnosis on cases closed from referral. In less than 80 cases was money spent on this service. With these figures in mind, the question arises as to how arbitrary are the counselors decisions about who is and who is not to receive service.

Clients referred by educational institutions were not given services in the majority of cases, approximately half of those referred by welfare agencies were not accepted for service, and for several other sources the same thing is true. Clients referred by medical sources have the greatest likelihood of receiving agency attention and of being rehabilitated.

This tendency to reject cases from educational institutions is undoubtedly related to the previously observed comparative lack of service to younger persons (those below the age of twenty). There is a wide overlap undoubtedly in these two groups. There should be further analysis of these cases. If these referrals are not eligible for one reason or another for the services of the agency, there would seem to be a need to interpret to educators just what the agency is equipped to do. There is inevitably going to arise a feeling of futility regarding the rehabilitation agency as a resource for students when referrals to the rehabilitation counselors are closed from referral with the high degree of regularity these figures indicate.

Disabling Conditions

A final factor relating to referrals, offering of services and closure of individual cases is the disabling condition or conditions of the client. These can be seen in Table 23. It is apparent that the agency does serve persons with a wide range of conditions, physical, mental and emotional.

**Table 23. Type of Disability, by Status of Client,
North Carolina, Fiscal Year**

<u>Type of Disability</u>	<u>Closed from Referral</u>		<u>Closed Not Rehabilitated</u>		<u>Closed Rehabilitated</u>		<u>Total</u>	
Orthopedic Impairment	737	(12.3%)	142	(20.4%)	1521	(16.9%)	2400	(15.3%)
Digestive Disorder	219	(3.7%)	61	(8.8%)	1408	(15.6%)	1688	(10.8%)
Mental Illness	341	(5.7%)	84	(12.1%)	942	(10.5%)	1367	(8.7%)
Kidney Condition	170	(2.8%)	61	(8.8%)	1094	(12.2%)	1325	(8.4%)
Mental Retardation	442	(7.4%)	72	(10.4%)	735	(8.2%)	1249	(8.0%)
Cardiac impairment	329	(5.5%)	74	(10.6%)	523	(5.8%)	926	(5.9%)
Hearing impairment	158	(2.6%)	22	(3.2%)	525	(5.8%)	705	(4.5%)
Allergies	185	(3.1%)	25	(3.6%)	375	(4.2%)	585	(3.7%)
Cancer	41	(2.6%)	18	(2.6%)	492	(5.5%)	551	(3.5%)
Visual impairment	266	(4.4%)	24	(3.5%)	231	(2.6%)	521	(3.3%)
Amputation	79	(1.3%)	35	(5.0%)	301	(3.3%)	415	(2.6%)
Respiratory disease	98	(1.6%)	26	(3.7%)	260	(2.9%)	384	(2.5%)
Nervous Condition	77	(1.3%)	9	(1.3%)	89	(1.0%)	175	(1.1%)
Speech	85	(1.4%)	12	(1.7%)	50	(0.6%)	147	(0.9%)
Diseases of Blood	20	(0.3%)	3	(0.4%)	13	(0.1%)	36	(0.2%)
Other & Unknown	2752	(45.9%)	27	(3.9%)	439	(4.9%)	3218	(20.8%)

Source: Records of the North Carolina Division of Vocational Rehabilitation, tabulated by Central Data Processing.

Of those referrals who received services and achieved their rehabilitation goal, the largest single group was composed of those suffering from orthopedic difficulties, followed by digestive disorders, mental illness and kidney conditions. Less common are diseases of the blood, speech and nervous conditions. For almost half of those closed from referral the disorder was either not ascertained or not reported.

Summary of Rehabilitation Services in the State as a Whole

To summarize briefly the record of the agency as a whole, rehabilitation rates exceed those for the nation. The group apparently least likely to receive services are those below the age of twenty, referred by educational institutions. Age ranges of those referred conform rather closely in other respects to the national picture. Women are somewhat more likely to seek services and to complete the rehabilitation program and reach their objective than men. In part this is probably related to the large number of women who are closed as homemakers. It is assumed that men are gainfully employed for the most part when the case is closed as rehabilitated.

Needs for services would presumably be greater among non-whites since these persons tend to be more economically deprived. It can be seen from agency records that while non-whites represented 25% of North Carolina's population according to the 1960 census, 36% of those rehabilitated by the agency in 1967 were non-white. This would suggest that an effort is made to meet the greater needs of this group.

The majority of those served by the agency have less than a high school education and more than one-fourth have less than nine years of school. Of those rehabilitated, the majority were placed in positions with wages or salaried income, with the exception of women rehabilitated as homemakers. A large number of those rehabilitated were subsequently employed in service occupations. This may be due in part to the relatively low educational level of clients at referral.

Medically oriented programs, including individual physicians, referred a high percentage of cases and a quite large proportion of those who received services and were rehabilitated.

COMPARISONS AMONG COUNTIES, DISTRICTS, AREAS AND REGIONS OF NORTH CAROLINA

It is of even greater importance to examine data concerning the various areas of the state and compare their functioning than to study the state-wide program. Since the period under study is several years away from the census figures tabulated in 1960, population projections (Perry and Hamilton, 1964) have been utilized to give a more accurate picture of the existing population of North Carolina in 1967. Rates have been calculated for areas, districts and counties on the basis of these projections. The population on which rates have been based is age-specific, i.e., those persons between the ages of 15 and 64, since these are the ages of persons most likely to utilize the resources of the rehabilitation agency.

Comparisons Among Areas

The agency is divided into six areas with offices in one or more centers in each area. These are:

- Western (offices in Asheville and Hickory)
- Northwestern (offices in Winston-Salem and Salisbury)
- Southwestern (offices in Charlotte)
- Central (offices in Chapel Hill, Durham and Greensboro)
- Northeastern (offices in Raleigh and Greenville)
- Southeastern (offices in Fayetteville, Goldsboro and Wilmington)

Table 24 gives the rehabilitation rate per ten thousand population in the aforementioned age range for each of these areas.

**Table 24. Age-Specific Rehabilitation Rates by Area, North Carolina,
Per 10,000 Population (Estimated 1967 Population**)**

<u>Area</u>	<u>Estimated 1967 Population</u>	<u>1967 Cases Closed</u>	<u>Rate per 10,000 Population</u>
Western	410,107	1,531	37.3
Northwestern	441,522	844	19.1
Southwestern	427,247	1,189	27.8
Central	534,010	1,071	20.1
Northeastern	556,245	1,988	35.7
Southeastern	538,524	2,264	42.0
Total	2,907,655	8,887	30.6

Sources:

- **1. Perry and Hamilton, 1960 Population Projections for North Carolina
 - 2. Records of the North Carolina Division of Vocational Rehabilitation.
-

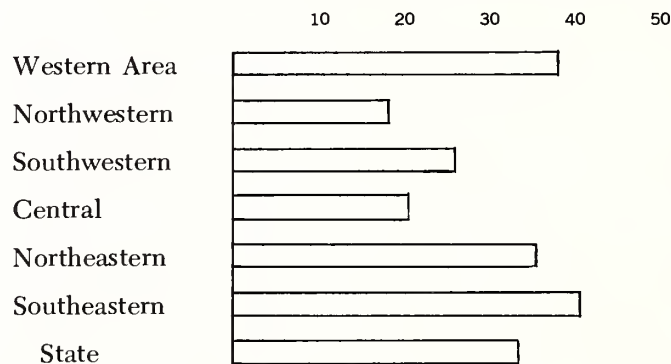
It is obvious that there are great differences among the areas in rates per 10,000 population. The eastern and western areas have much higher rates than those areas located in the more heavily industrialized piedmont sections. It is, of course, possible that in these piedmont counties where there

are more medical facilities and a wider range of other services, the rehabilitation agency is only one of several resources of clients whereas in the less economically prosperous portions, there are fewer alternative resources the potential client may seek. There would possibly be less likelihood of "shopping" agencies on the part of disabled persons in eastern and western counties.

Since there is no available information, except for the sampling of counties cited later in the paper, other than that which can be assumed from the disabilities served and placements after rehabilitation, about the types of services offered to clients, this, too, would be an important area to be investigated in making completely valid evaluation of the effectiveness of programs in different areas.

If services are comprised primarily of authorizing medical treatments, surgery or short-termed therapy after which the client can return to a previous occupation or is enabled to seek employment as relatively non-disabled, the time involved and the degree of counseling skill is considerably less than with more difficult cases where counseling, therapy and probably training programs are all involved. While the need for the first type of service is evident, the greatest need is probably exhibited by the clients of the agency who must have a variety of different kinds of service before becoming employable.

Figure 17. Number of Rehabilitations (Ages 15-64) Per 10,000 Population (Ages 15-64), By Area



District Comparisons

Similarly, rates per 10,000 population were computed for each of the district offices to get some internal comparisons within each area.

**Table 25. Age-Specific Rehabilitation Rates per 10,000 Population
By District, North Carolina, Estimated 1967 Population**

District	Estimated 1967 Population	1967 Cases Closed	Rates per 10,000 Population
Asheville	220,808	876	39.7
Hickory	189,199	655	34.6
Winston-Salem	305,548	520	17.0
Salisbury	135,938	324	23.8
Charlotte	427,247	1,189	27.8
Chapel Hill	110,226	118	10.7
Greensboro	294,117	461	15.7
Durham	129,667	492	37.9
Raleigh	279,309	1,197	42.9
Greenville	276,936	791	28.6
Fayetteville	235,313	1,047	44.5
Goldsboro	125,364	660	52.6
Wilmington	177,847	557	31.3
Total	2,907,655	8,887	30.6

Sources: 1. Perry and Hamilton, 1980 Population Projections for North Carolina.
2. Records of the North Carolina Division of Vocational Rehabilitation

Just as there are variations in rates within the state, there are variations within areas. From the above compilation, it is apparent there is no consistency from one district to another, and while the cities of the piedmont do tend to have lesser rates, this is not consistently true even in this section of the state.

County Rates

A county rating per 10,000 population can be seen in Table 26. The county with the highest rate is Polk (110.7), followed by Swain and Hoke, all of which had rates of over 100 per 10,000 population. The poorest rate appears in Randolph county with only 5.6 per 10,000 population. Figure 18 graphically shows the counties of the state with their rehabilitation rates. High ranking counties, as previously noted from the tables, tend to be found in the far western and southeastern parts of North Carolina.

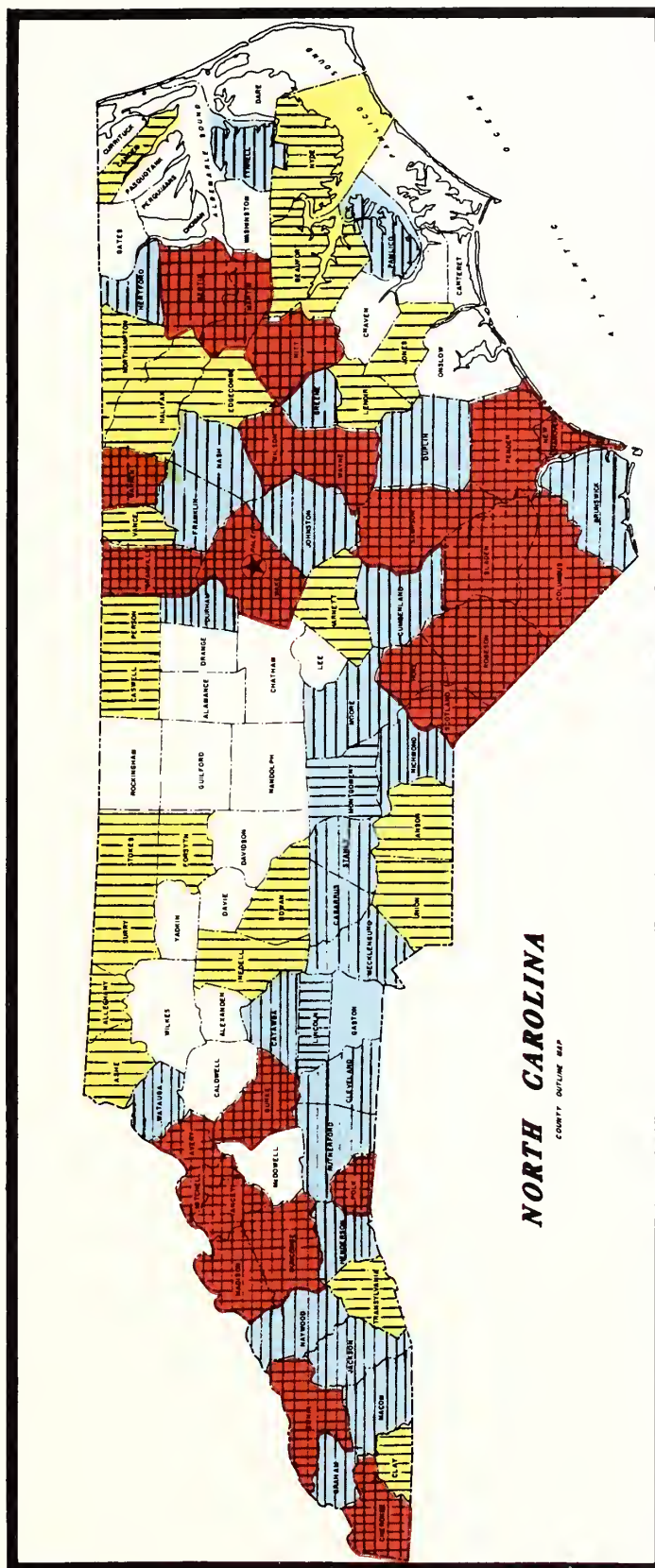
Table 26. Age-Specific Rehabilitation Rates per 10,000 Population
Ranked by County, North Carolina, 1967 Estimated Population (Ages 15-64)

<u>County</u>	<u>Rate</u>	<u>Rank*</u>	<u>County</u>	<u>Rate</u>	<u>Rank*</u>
Alamance	14.3	85	Johnston	28.3	45
Alexander	13.4	92	Jones	20.2	68
Alleghany	23.1	60	Lee	15.2	83
Anson	25.4	54	Lenoir	18.9	70
Ashe	22.9	61	Lincoln	22.8	63
Avery	56.3	13	McDowell	10.4	95
Beaufort	24.7	56	Macon	32.2	33
Bertie	53.7	14	Madison	48.1	21
Bladen	77.2	7	Martin	49.2	19
Brunswick	39.2	28	Mecklenburg	34.4	30
Buncombe	40.1	25	Mitchell	78.1	6
Burke	75.9	8	Montgomery	23.2	59
Cabarrus	25.1	55	Moore	34.1	32
Caldwell	13.4	91	Nash	39.6	27
Camden	22.4	64	New Hanover	41.8	24
Carteret	14.3	84	Northampton	29.0	41
Caswell	18.8	71	Onslow	5.8	99
Catawba	28.1	47	Orange	13.2	93
Chatham	14.1	87	Pamlico	30.9	38
Cherokee	42.8	23	Pasquotank	12.3	94
Chowan	8.1	98	Pender	49.8	17
Clay	24.6	58	Perquimans	16.7	77
Cleveland	27.7	48	Person	26.7	51
Columbus	53.0	15	Pitt	61.3	10
Craven	8.6	96	Polk	110.7	1
Cumberland	25.6	53	Randolph	5.6	100
Currituck	15.4	81	Richmond	27.2	50
Dare	13.4	90	Robeson	65.2	9
Davidson	15.2	82	Rockingham	13.9	88
Davie	16.1	79	Rowan	21.4	65
Duplin	39.7	26	Rutherford	28.2	46
Durham	30.0	39	Sampson	49.9	16
Edgecombe	22.8	62	Scotland	48.4	20
Forsyth	18.3	73	Stanly	27.6	49
Franklin	28.7	44	Stokes	20.8	66
Gaston	15.4	80	Surry	17.4	76
Gates	14.2	86	Swain	108.2	2
Graham	31.5	37	Transylvania	17.5	75
Granville	89.8	4	Tyrrell	31.8	35
Greene	28.9	43	Union	20.2	67
Guilford	16.4	78	Vance	24.7	57
Halifax	19.8	69	Wake	59.4	11
Harnett	18.6	72	Warren	49.4	18
Haywood	29.7	40	Washington	17.7	74
Henderson	31.7	36	Watauga	32.0	34
Hertford	34.3	31	Wayne	78.7	5
Hoke	100.3	3	Wilkes	13.6	89
Hyde	29.0	42	Wilson	47.6	22
Iredell	25.7	52	Yadkin	8.5	97
Jackson	35.4	29	Yancey	58.8	12

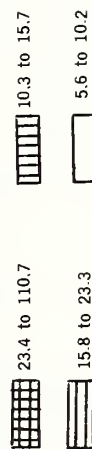
*These ranks were calculated to the nearest hundredth.

Sources: Based on 1. Perry and Hamilton, 1980 Population Projections for North Carolina.
2. Records of the North Carolina Division of Vocational Rehabilitation.

Figure 18
Age-Specific Rehabilitation Rates (Ages 15-64) Per 10,000 Population
By County—North Carolina, Estimated 1967 Population



LEGEND:
 Rehabilitation per 10,000 population:



SOURCES:

- 1) Perry, Josef H. and Dr. Horace Hamilton, 1980 Population Projections for North Carolina Counties, January, 1964.
- 2) Records of the North Carolina Division of Vocational Rehabilitation

Table 27 shows the rate per 10,000 population for each county for whites and nonwhites. Overall rates for the state indicate more rehabilitations among nonwhites than whites, but this varies from county to county. In counties with relatively small nonwhite populations, there seem to be lower rates for nonwhites—i.e., Ashe, Graham, Mitchell.

Table 28 gives the rates for males and females by counties. By and large more females were rehabilitated during this period. In a number of counties there were relatively small sex differences in rate.

**Table 27. Rehabilitation Rated per 10,000 Population, by County
and Race, North Carolina, 1967 Population Estimates**

County	White Rate ¹	Nonwhite Rate ²	County	White Rate ¹	Nonwhite Rate ²
Alamance	8	13	Johnston	17	15
Alexander	7	18	Jones	4	17
Alleghany	11	95	Lee	8	14
Anson	12	16	Lenoir	13	8
Ashe	13	0	Lincoln	13	20
Avery	33	172	McDowell	7	0
Beaufort	11	18	Macon	17	121
Bertie	16	38	Madison	30	0
Bladen	39	47	Martin	18	37
Brunswick	20	33	Mecklenburg	14	42
Buncombe	23	40	Mitchell	47	0
Burke	46	69	Montgomery	14	14
Cabarrus	14	26	Moore	14	37
Caldwell	8	13	Nash	16	34
Camden	9	16	New Hanover	23	35
Carteret	8	7	Northampton	12	18
Caswell	12	9	Onslow	3	6
Catawba	15	41	Orange	6	16
Chatham	7	12	Pamlico	22	8
Cherokee	26	22	Pasquotank	4	12
Chowan	3	6	Pender	29	26
Clay	14	0	Perquimans	2	18
Cleveland	15	24	Person	12	22
Columbus	26	40	Pitt	23	54
Craven	5	4	Polk	57	113
Cumberland	12	26	Randolph	4	2
Currituck	6	14	Richmond	16	16
Dare	8	0	Robeson	20	45
Davidson	10	8	Rockingham	7	1
Davie	9	15	Rowan	13	15
Duplin	22	25	Rutherford	15	33
Durham	15	28	Sampson	26	34
Edgecombe	10	14	Scotland	25	29
Forsyth	10	14	Stanly	17	18
Franklin	13	22	Stokes	12	2
Gaston	9	15	Surry	11	10
Gates	5	10	Swain	58	69
Graham	19	0	Transylvania	10	21
Granville	71	29	Tyrrell	9	27
Greene	15	18	Union	9	26
Guilford	10	10	Vance	12	16
Halifax	8	14	Wake	32	58
Harnett	11	11	Warren	13	32
Haywood	18	22	Washington	11	8
Henderson	17	54	Watauga	22	43
Hertford	13	24	Wayne	47	45
Hoke	42	66	Wilkes	8	4
Hyde	10	23	Wilson	20	40
Iredell	14	22	Yadkin	5	18
Jackson	20	36	Yancey	33	330

¹ Per 10,000 white population

² Per 10,000 nonwhite population

Sources: Based on 1. 1960 Census of Population

2. Perry and Hamilton, 1980 Population Projections for N. C.

3. Records of the North Carolina Division of Vocational Rehabilitation.

Table 28. Rehabilitation Rates per 10,000 Population, by County and Sex, North Carolina, 1967 Population Estimates

<u>County</u>	<u>Male</u>	<u>Female</u>	<u>County</u>	<u>Male</u>	<u>Female</u>
Alamance	9	8	Johnston	13	21
Alexander	10	6	Jones	9	13
Alleghany	8	19	Lee	6	12
Anson	13	15	Lenoir	14	8
Ashe	10	16	Lincoln	15	12
Avery	28	42	McDowell	8	5
Beaufort	11	17	Macon	15	22
Bertie	25	33	Madison	28	32
Bladen	28	56	Martin	16	38
Brunswick	19	27	Mecklenburg	19	23
Buncombe	22	26	Mitchell	49	45
Burke	52	44	Montgomery	21	8
Cabarrus	11	22	Moore	15	24
Caldwell	10	7	Nash	16	30
Camden	7	17	New Hanover	29	24
Carteret	8	8	Northampton	10	21
Caswell	8	13	Onslow	4	4
Catawba	14	2	Orange	4	14
Chatham	11	6	Pamlico	19	14
Cherokee	30	21	Pasquotank	2	12
Chowan	4	5	Pender	25	31
Clay	23	4	Perquimans	7	9
Cleveland	15	19	Person	14	17
Columbus	25	36	Pitt	25	46
Craven	7	4	Polk	53	73
Cumberland	13	19	Randolph	4	3
Currituck	9	9	Richmond	12	2
Dare	0	16	Robeson	29	4
Davidson	12	7	Rockingham	9	8
Davie	10	9	Rowan	11	16
Duplin	20	26	Rutherford	14	19
Durham	16	22	Sampson	29	29
Edgecombe	9	16	Scotland	28	26
Forsyth	13	9	Stanly	16	20
Franklin	19	15	Stokes	14	11
Gaston	11	8	Surry	17	6
Gates	5	11	Swain	47	74
Graham	24	13	Transylvania	10	12
Granville	52	54	Tyrrell	15	20
Greene	19	14	Union	15	11
Guilford	11	9	Vance	10	18
Halifax	8	14	Wake	31	45
Hamett	11	12	Warren	20	32
Haywood	18	18	Washington	9	10
Henderson	18	19	Watauga	20	25
Hertford	8	30	Wayne	36	57
Hoke	54	56	Wilkes	5	11
Hyde	8	23	Wilson	13	42
Iredell	16	15	Wadkin	8	4
Jackson	20	23	Yancey	34	38

Sources: Based on 1. 1960 Census of Population

2. Perry and Hamilton, 1980 Population Projections for N. C.

3. Records of the North Carolina Division of Vocational Rehabilitation

Disabling Conditions Compared by Area

The percentage of clients having specific kinds of disabilities did not vary greatly from one district to another. As can be seen in Table 29, the percentage of each disability found among the rehabilitees follows in each district about the same pattern as that found in the state as a whole.

**Table 29. Disabling Conditions Among Rehabilitated Clients,
by Area, for Fiscal Year 1967**

Type of Disability	Western	Northwest	Southwest	Central	Northeast	Southeast
Number	1551	859	1213	1075	2010	2290
	%	%	%	%	%	%
Visual	1.9	4.0	1.5	3.0	3.3	2.2
Hearing & Speech	7.0	9.1	6.9	5.1	5.7	6.2
Orthopedic & Amputation	20.7	29.1	25.1	20.9	15.3	17.8
Mental Illness	13.5	6.4	10.2	18.7	8.8	11.7
Mental Retardation	8.8	14.4	7.1	11.3	4.9	7.2
Diseases of Blood, Allergies, Kidney	13.5	14.0	14.3	14.5	20.3	18.2
Cancer	2.0	2.6	1.8	3.7	10.3	7.4
Cardiac	7.3	4.5	7.4	5.6	5.1	5.2
Respiratory	3.2	2.8	1.7	1.7	1.4	5.2
Digestive Disorders	18.7	7.9	12.2	12.0	19.8	16.4
Other, Not reported	3.5	5.1	11.7	3.6	5.0	2.5
Total	100.1	99.9	99.9	100.1	99.9	100.0

Source: Records of the North Carolina Division of Vocational Rehabilitation

Sources of Referral Compared by Area

Table 30 gives the percentage of referrals to the agency in each district of the state. In studying the table it can be seen that in some districts more referrals come from certain sources than from others. For example, in the Northwestern and Central areas, educational institutions refer a number of cases. The low rates of these areas taken in conjunction with the large number of cases closed without offering any services that are referred by educational institutions would suggest that these areas should give serious consideration to this. Medical sources are, in every district, a major source of referrals, but physicians apparently refer more cases in these areas that do not have major clinics or teaching hospitals, since both the Southwestern (Charlotte) and the Central (Chapel Hill, Durham, Greensboro) areas have a larger percentage referred from hospitals and sanatoriums than from physicians. For other sources, percentages tend to vary somewhat less.

**Table 30. Percentage of Referrals from Various Sources, by Area,
North Carolina, Fiscal Year 1967**

Source	Area					
	Western	Northwest	Southwest	Central	Northeast	Southeast
Educational institutions	9.1	19.6	5.3	16.8	5.5	8.3
Hospitals & Sanatoriums	17.9	14.0	35.4	40.2	22.0	3.7
Other Health Agencies	3.1	3.2	3.2	3.1	2.1	3.7
Physicians	29.3	29.4	27.0	18.0	39.3	44.0
Social Security	0.4	0.5	0.4	0.2	0.1	0.0
Workmen's Compensation	0.1	0.0	0.2	0.1	0.0	0.1
Welfare	13.0	9.4	7.8	7.4	6.9	6.4
E.S.C.	1.0	2.8	2.5	2.0	1.1	0.4
Artificial Appliances	3.5	3.7	4.0	1.8	3.1	2.8
Other Person	7.4	7.1	3.0	4.5	7.2	4.6
Self	11.3	8.3	7.0	4.6	10.3	8.5
Other	3.9	2.0	4.2	0.9	2.4	1.5

Source: Records of the North Carolina Division of Vocational Rehabilitation

Counselor Services in Selected Counties

Comparative information was accumulated on fifteen counties, ten with high rehabilitation rates and five with low rates. The ten high counties were divided between the eastern and western portions of the state and the five low counties were taken from the piedmont. High counties were: Cherokee, Madison, Mitchell, Swain and Yancey in the west; Bertie, Columbus, Martin, New Hanover and Sampson in the east. Low counties were: Alamance, Davidson, Forsyth, Guilford and Orange. Counselors were asked to designate primary and secondary services rendered.

In the high rated counties, from 67% to 92% of the cases involved physical restoration as a primary service in the western counties; 76% to 100% in the eastern counties. In the counties with lower rates Forsyth had only 24% of cases involving this as a primary service while Alamance and Orange had selected counties reported counseling as a primary service and the county with the highest percentage selected counties reported counseling as a primary service and the county with the highest percentage where job training was a primary service was Cherokee (25%). Mitchell and Columbus counties used no job training. In the piedmont, Forsyth had 50% of their cases where job training was a primary service, Davidson, 52% and Guilford 42%. It seems evident, then, that some of the counties with lower gross rates of rehabilitations are actually offering clients more services, and services that demand more counselor time and effort than several counties that report very high rates.

Further evidence of this can be seen in comparing these counties in terms of rendering placement services as a primary effort. Only one eastern county, New Hanover, even reported this as a primary service and this for only one case. The same is true of the western counties only Mitchell had one case in which placement was a primary service. Forsyth and Guilford counties had nine and eight cases respectively in this category, although the other three Piedmont counties had no cases.

Counseling is apparently viewed as an unimportant service for clients by the counselors themselves. None of the western and eastern counties reported counseling as a primary service and in only Forsyth and Guilford was it mentioned and here for only a total of three clients. As a secondary service counseling was reported for 148 clients. Counties represented were:

No. Cases	Counties Reporting
29	Guilford
28	Forsyth
25	New Hanover
16	Alamance
12	Mitchell
9	Orange, Madison, Yancey
5	Davidson
2	Sampson, Bertie
1	Columbus, Martin
0	Cherokee, Swain

From this it can be assumed that the counselors put relatively little value on themselves as a resource for clients. While it is unlikely that counseling was not involved in services rendered clients; from the preceeding it is apparent that counselors themselves do not regard their time spent with the client as a primary aid in the rehabilitation process and in only a part of the cases as even a secondary assistance. This may reflect lack of training in counseling among the counselors or a feeling that the counseling process is not highly regarded administratively.

It would seem that there is a tendency, especially in some counties with high rehabilitation rates, to accept a disproportionate number of clients whose needs can be met by minimal effort on the part of the counselor (physical restoration) and once these immediate problems are solved can be expected to rehabilitate themselves. Only in the piedmont counties, where rehabilitation rates are lower, are services of a broader nature rendered. Rates of rehabilitation are a deceptive indicator, therefore, of the quality of services.

The findings mentioned in the previous paragraphs are reported more fully in another study,¹ but attention is called to them here since they do give some information about the kind and quality of services being rendered. The piedmont counties with low rates are also the counties that are at least making an attempt to serve some of the younger clients who are so frequently closed from referral throughout the state. Table 31 below shows that acceptance for services is highly selective and that once a client has been screened, he is likely to be rehabilitated. The nature of the selective process does, however, as shown in the sample counties, vary from counselor to counselor.

¹See Appendix VII, page 222.

Table 31. Percentage of Cases Closed From Referral, Closed not Rehabilitated and Closed Rehabilitated, by Source of Referral, Fiscal Year 1967

<u>Referral Source</u>	<u>Percent of Cases Closed from Referral</u>	<u>Percent of Remaining Closures that were Closed: Not Rehabilitated</u>	<u>Rehabilitated</u>
Educational Institutions	62.24	6.75	93.25
Hospitals and Sanatoriums	23.33	7.83	92.17
Other Health Agencies	41.37	8.03	91.97
Physicians	20.96	6.60	93.40
Social Security Administration	95.18	9.52	90.48
Workmen's Compensation Agencies	67.86	22.22	77.78
Welfare Agencies	50.63	10.49	89.51
State Employment Service	52.63	13.89	86.11
Artificial Appliance Company	22.79	2.78	97.22
Interested Individual	38.52	3.58	96.42
Self-Referred Person	43.50	6.79	93.21
Other Sources	44.51	6.95	93.05
Correctional Institutions	50.67	5.41	94.59
Not Reported	38.46	12.50	87.50

Source: Records of the North Carolina Division of Vocational Rehabilitation

Table 32. Percentage of Clients Closed from Referral and Percentage Closed Rehabilitated, by Type of Disability, North Carolina 1967

<u>Disabilities by Rank Order Closed</u>	<u>Percent Closed From Referral</u>	<u>Percent Served Who Were Closed Rehabilitated</u>
Orthopedic	30.7	91.4
Mental Illness	25.2	91.8
Mental Retardation	36.1	91.1
Kidney	12.3	95.5
Hearing	22.5	96.3
Respiratory	29.9	92.2
Hcart	48.1	79.5
Visual	51.1	90.6
Amputation	19.0	89.6
Diabetes	25.2	91.3
Stroke	40.8	88.1
Emphysema	69.3	87.5
Cancer	38.4	100.0

Source: Records of the North Carolina Division of Vocational Rehabilitation

CONCLUSIONS

While North Carolina compares quite favorably with the United States as a whole, and there is reason for the agency to take considerable satisfaction in its record during the fiscal year under consideration, it would be well to examine the records for the ensuing months to determine if certain trends are still in evidence.

There should be considerable consideration given to meeting the needs of younger clients. The productive years of those under twenty are extensive, and their economic well-being, not to mention their social and emotional adjustments, would seem to be important during these formative years. At this age training of relatively extensive nature is both feasible and desirable, since these younger clients will have an opportunity to not only be self-sustaining but productive citizens maintaining families for many years.

In addition to the type of reporting on which this analysis is based, it would be important to have complete information accumulated for the entire state on the kinds of services rendered by counselors to clients. This would make for more effective evaluation of counselor efficiency and enable the agency to plan better for the use of the training that each counselor has. The actual process of counseling is not only more time-consuming but demands greater skill than less complex problems demand. Counselor services should be evaluated in terms of the processes involved and the degree of training and preparation needed to perform each level of service.

With the high percentage of referrals from certain sources that apparently seemed to be unlikely to succeed in a rehabilitation program or who appeared to be ineligible for services, each area should seriously consider developing more efficient public information channels and better interpretation of what the agency is equipped to do at present and what added facilities could be contemplated if the need exists. Particular consideration should be given not only to cases which have been accepted for rehabilitation programming, but to the large number of cases which were closed from referral. There should be analysis of the reasons these cases were not opened and given the opportunity to participate in the agency program. From this there is a possibility that groups not now being served could have programs developed to meet their needs. This is important.

APPENDIX VII

Characteristics of Clients Closed in Status 26 in Selected North Carolina Counties, by Region, Fiscal Year 1967

As was mentioned on page 236 of the preceding report, a 20 percent random sample study of all Status 26 closures was completed in fifteen counties. Ten of the counties, from the eastern and western parts of the state, represented areas of proportionately high rehabilitation production rates. Five counties representative of those with lower rehabilitation production rates were selected from the piedmont area of the state.

The analysis of closures, presented in the tables on the following pages, indicates there are significant differences between the rehabilitations being turned in by the low producing counties and those being accomplished in the highly productive counties. In fact, it would seem that closures from the highly productive areas are by nature more of a maintenance service than rehabilitation. The Agency is serving people well beyond the high school graduation age who have lived very marginally independent lives in their communities. These persons are characterized by low educational achievement, a history of sporadic employment, and have lived just under or above the poverty level throughout their lives. The vocational rehabilitation services being provided correct only acute physical disability and after closure the "rehabilitant" must still contend with chronic problems that adversely affect his economic opportunities. These facts point out very dramatically needs which are going unmet.

There is no question but that the Vocational Rehabilitation Agency is providing a valuable service in that at the time physical restoration is provided it is undoubtedly the most acute need of the client. With this available information the Agency should evaluate ways in which needed additional services can be provided by the Agency or some other resource equipped specifically to deal with the client's chronic problems.

Even if the client is referred to another agency, the general feeling is that the case should be kept open for counseling and guidance services until a more suitable life situation is achieved.

APPENDIX VIII

As mentioned throughout the section on "Managerial Data, a Statistical Analysis of Program Practices and Professional Personnel in North Carolina, 1966-1967", and on page 240 there are indications of a great need to further evaluate cases that are being closed in Status 08. Also as has been mentioned in the aforementioned section of this report, very small amounts of money are being spent on diagnosis of persons before their closure in Status 08. On page 261 "Report of Counselor Caseload Practice Survey" it may be seen that the number one reason reported by counselors for closing cases in Status 08 was that "the applicant has no disability", also as mentioned on page 262 of the same section there is information to indicate that vocational rehabilitation counselors make almost no use of tests or other guidance instruments. Viewing all of this information in perspective, it would appear that there may be many referrals to the Vocational Rehabilitation Agency being closed in Status 08 because of no *apparent* disability or handicap. However, it seems logical to assume that if a referral is made, there would be very little likelihood that the referred individual does not have a problem which needs attention. It is felt that probably many of the handicaps which are not recognized are psycho social handicaps that can be revealed only by more complete diagnosis. A recommendation to alleviate this situation may be found after the following tables. The Vocational Rehabilitation Agency is in agreement with this recommendation and has requested some of the positions suggested in its B Budget request.

RECOMMENDATION

The Governor's Study Committee on Vocational Rehabilitation submits the following recommendation:

The State of North Carolina should strongly urge and support its Division of Vocational Rehabilitation in further developing its capacity to provide adequate psychological services in all cases to the degree needed. In order to provide such services, it is recommended that the Vocational Rehabilitation Agency should employ at least 12 agency psychologists who would work under the supervision and guidance of the agency's present psychological consultant. These individuals would not be employed to diagnose disability (such psychological services are already available on a purchased service basis) but would direct their efforts toward assessing the vocational limitation and potential of each client. A further responsibility, which should be assigned to these individuals, would be to consult with the vocational rehabilitation counselor concerning the subtleties of an applicant's condition which may have precipitated his coming to the Division of Vocational Rehabilitation for help. This responsibility is of particular importance in those cases which would not ordinarily be referred for a full psychological or psychiatric evaluation.

An investigation of the Vocational Rehabilitation Agency operation reveals that the vocational rehabilitation counselors now employed do almost no vocational aptitude, interest, dexterity or motivational testing. The agency and its counselors seem to realize that this is a crucial part of vocational counseling and guidance service so essential to rehabilitation, but present resources and limited staff mitigate against becoming involved in these guidance practices. Actually, it would be extremely inefficient for the vocational rehabilitation counselor to perform in these areas for himself because all of the assessment instruments that the average counselor is qualified to use are designed for use with a group. To use such evaluation tools on an individual case basis would be far more costly than would be legitimate.

If agency psychologists were employed for the express purpose of operating a group testing program, it is felt that the Agency would achieve much more efficiency and could build up in these individuals charged to concentrate on a single aspect of service, a rapid development of specific professional skills. Since there is an extreme shortage of manpower, it would be to great advantage to have all of these individuals not only receiving supervision and guidance from the agency's psychological consultant, but they should also receive regular instructions from this person related to the application of general psychological theories to the practice of vocational rehabilitation.

Such a program would be as follows:

1. Professional Personnel	(12)	\$120,000.00
2. Clerical Personnel	(12)	51,132.00
3. Office Space		12,000.00
4. Equipment		12,180.00
5. Travel		14,400.00
6. Materials		9,000.00
		\$218,712.00

State share: \$54,678

Table 33

**Selected Eastern North Carolina Counties with High Rehabilitation Rates,
Fiscal Year 1967**

<u>Residence</u>	<u>Bertie</u> No.	<u>Columbus</u> No.	<u>Martin</u> No.	<u>New Hanover</u> No.	<u>Sampson</u> No.
	%	%	%	%	%
Rural farm	3	10	5	—	6
Rural non-farm	5	11	8	5	16
Urban	—	5	1	4	5
Metropolitan	—	—	—	27	—
Unknown	5	2	—	5	—
Total	13	28	14	41	27
	23.0	35.7	35.7	—	22.2
	38.5	39.3	57.1	12.2	59.3
	—	17.9	7.1	9.8	18.5
	—	—	—	65.8	—
	38.5	7.1	—	12.2	—
	100.0	100.0	99.9	100.0	100.0
<u>Disability</u>					
Mental illness	—	—	—	1	—
Mental retardation	1	—	1	6	—
Physical	12	28	13	34	27
Total	13	28	14	41	27
	7.7	—	—	2.4	—
	92.3	100.0	92.9	82.9	100.0
	100.0	100.0	100.0	99.9	100.0
<u>Marital Status</u>					
Married	6	21	10	20	18
Single	5	2	2	12	4
Divorced	2	—	—	3	1
Widowed	—	4	1	2	1
Separated	—	1	1	4	3
Total	13	28	14	41	27
	46.1	75.0	71.5	48.8	66.7
	38.5	7.1	14.3	29.3	14.8
	15.4	—	—	7.3	3.7
	—	14.3	7.1	4.9	3.7
	—	3.6	7.1	9.8	11.1
	100.0	100.0	100.0	100.0	100.0

* Based on a 20% random sample from each county rehabilitated in fiscal year 1967.

Table 33 (cont.)

	Bertie		Columbus		Martin		New Hanover		Sampson	
	No.	%	No.	%	No.	%	No.	%	No.	%
<u>Age at referral</u>										
Less than 20 years	—	—	1	3.6	—	—	5	12.2	4	14.8
20-34 years	6	46.1	4	14.3	4	28.6	18	43.9	8	29.6
35-44 years	3	23.1	7	25.0	7	50.0	11	26.8	7	25.9
45-64 years	4	30.8	16	57.1	3	21.4	6	14.6	8	29.6
65 and over	—	—	—	—	—	—	1	2.4	—	—
Total	13	100.0	28	100.0	14	100.0	41	99.9	27	99.9
Average Age	40		46.4		37.2		33.3		36.2	
<u>Race</u>										
White	3	23.1	15	53.6	3	21.4	30	73.2	15	55.6
Non-white	10	76.9	13	46.4	11	78.6	11	26.8	12	44.4
Total	13	100.0	28	100.0	14	100.0	41	100.0	27	100.0
<u>Sex</u>										
Male	4	30.8	7	25.0	5	35.7	22	53.7	14	51.9
Female	9	69.2	21	75.0	9	64.3	19	46.3	13	48.1
Total	13	100.0	28	100.0	14	100.0	41	100.0	27	100.0
<u>Grade Completed</u>										
None	—	—	1	3.6	1	7.1	—	—	—	—
1-7	9	69.2	18	64.3	6	42.9	14	34.1	8	29.6
8	1	7.7	6	21.4	4	28.6	5	12.2	4	14.8
9-11	2	15.4	3	10.7	2	14.3	14	34.1	9	33.3
12	1	7.7	—	—	1	7.1	5	12.2	6	22.2
13-15	—	—	—	—	—	—	2	4.9	—	—
16 and over	—	—	—	—	—	—	—	—	—	—
Special Ed.	—	—	—	—	—	—	1	2.4	—	—
Total	13	100.0	28	100.0	14	100.0	41	99.9	27	99.9

Table 33 (cont.)

	Bertie		Columbus		Martin		New Hanover		Sampson	
	No.	%	No.	%	No.	%	No.	%	No.	%
Primary Service Rendered										
Physical Restoration	12	92.3	28	100.0	12	85.7	31	75.6	22	81.5
Job Training	1	7.7	—	—	2	14.3	6	14.6	3	11.1
Counseling	—	—	—	—	—	—	—	—	—	—
Placement	—	—	—	—	—	—	1	2.4	—	—
Other	—	—	—	—	—	—	—	—	2	7.4
Not noted	—	—	—	—	—	—	3	7.3	—	—
Total	13	100.0	28	100.0	14	100.0	41	99.9	27	100.0
Other Services Rendered										
Physical Restoration	—	—	—	—	1	—	4	—	1	—
Job Training	—	—	—	—	—	—	3	—	—	—
Counseling	2	—	1	—	1	—	25	—	2	—
Job Placement	1	—	—	—	1	—	3	—	—	—
Other	2	—	—	—	—	—	9	—	1	—
Estimated Cost of Service (average)	\$303.52		\$322.50		\$369.96		\$457.75		\$530.10	
Months from Acceptance to Closure										
6 months or less	10	76.9	13	46.4	10	71.5	15	36.6	8	29.6
7-12 months	2	15.4	9	32.1	1	7.1	7	17.1	11	40.7
13-18 months	—	—	4	14.3	2	14.3	5	12.2	3	11.1
19-36 months	1	7.7	1	3.6	—	—	10	24.4	4	14.8
37 or more	—	—	1	3.6	1	7.1	4	9.8	1	3.7
Total	13	100.0	28	100.0	14	100.0	41	100.0	27	99.9
Media no.	5.0		7.0		4.0		11.0		9.0	

Table 33 (cont.)

Weekly Earnings on Last Job Held Prior to Acceptance	Bertie		Columbus		Martin		New Hanover		Sampson	
	No.	%	No.	%	No.	%	No.	%	No.	%
Farmers, homemakers, or unpaid family workers										
Less than \$10 wk.										
10-19	6	46.1	21	75.0	9	64.3	13	31.7	10	37.0
20-39	—	—	—	—	1	7.1	1	2.4	1	3.7
40-59	2	15.4	2	7.1	2	14.3	4	9.8	—	—
60-79	2	15.4	4	14.3	2	14.3	6	14.6	4	14.8
80-over	3	23.1	1	3.6	—	—	9	22.0	7	25.9
	—	—	—	—	—	—	7	17.1	4	14.8
	—	—	—	—	—	—	1	2.4	1	3.7
Total	13	100.0	28	100.0	14	100.0	41	100.0	27	99.9
Job Status at Acceptance										
Employed	4	30.8	4	14.3	2	14.3	12	29.3	6	22.2
Unemployed	3	23.1	8	28.5	4	28.6	19	46.3	11	40.7
Household worker (own home)	6	46.1	15	53.6	6	40.9	5	12.2	6	22.2
Other	—	—	1	3.6	2	14.3	5	12.2	4	14.8
Total	13	100.0	28	100.0	14	100.1	41	100.0	27	99.9

Table 33 (cont.)

Weekly Earnings at Acceptance		Bertie		Columbus		Martin		New Hanover		Sampson	
No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
8	61.5	25	89.3	12	85.7	27	65.9	21	77.8		
2	15.4	—	—	1	7.1	1	2.4	1	3.7		
—	—	2	7.1	—	—	2	4.9	—	—		
1	7.7	1	3.6	1	7.1	4	9.8	2	7.4		
2	15.4	—	—	—	—	5	12.2	2	7.4		
—	—	—	—	—	—	2	4.9	—	—		
—	—	—	—	—	—	—	—	1	3.7		
13	100.0	28	100.0	14	99.9	41	100.0	27	100.0		
Total											
Weekly Earnings at Closure		Bertie		Columbus		Martin		New Hanover		Sampson	
No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
6	46.1	20	71.4	10	71.5	7	17.1	8	29.6		
—	—	—	—	—	—	—	—	—	—		
1	7.7	2	7.1	1	7.1	6	14.6	—	—		
2	15.4	5	17.9	1	7.1	5	12.2	4	14.8		
4	30.8	1	3.6	1	7.1	12	29.3	8	29.6		
—	—	—	—	—	—	10	24.4	4	14.8		
—	—	—	—	1	7.1	1	2.4	3	11.1		
13	100.0	28	100.0	14	99.9	41	100.0	27	99.9		
Total											

Table 34

Selected Piedmont North Carolina Counties with Low Rehabilitation Rates Fiscal Year 1967*

	Alamance No.	Davidson No.	Forsyth No.	Guliford No.	Orange No.
<u>Residence</u>					
Rural farm	—	—	—	2	—
Rural non-farm	6	7	1	12	7
Urban	9	10	5	1	2
Metropolitan	—	—	44	45	—
Unknown	2	—	—	—	—
Total	17	17	50	60	9
	100.0	100.0	100.0	100.0	100.0
<u>Disability</u>					
Mental Illness	—	2	2	5	1
Mental Retardation	—	3	17	10	—
Physical	17	12	31	45	8
Total	17	17	50	60	9
	100.0	100.0	100.0	100.0	100.0
<u>Marital Status</u>					
Married	10	5	13	20	7
Single	3	10	27	28	1
Divorcee	2	2	2	4	—
Widowed	—	—	1	1	—
Separated	2	—	7	7	1
Total	17	17	50	60	9
	100.0	100.0	100.0	100.1	100.0

*Figures are based on a 20% random sample drawn from the "closed rehabilitated" cases in each county.

Table 34 (cont.)

Age of referral		Alamance No.	%	Davidson No.	%	Forsyth No.	%	Guilford No.	%	Orange No.	%
Less than 20 years		1	5.9	7	41.2	17	34.0	21	35.0	—	—
20-34 years		4	23.5	3	17.6	17	34.0	18	30.0	1	11.1
35-44 years		5	29.4	2	11.8	10	20.0	12	20.0	5	55.6
45-64 years		6	35.3	5	29.4	6	12.0	8	13.3	3	33.3
65 years and over		—	—	—	—	—	—	1	1.7	—	—
Not noted		1	5.9	—	—	—	—	—	—	—	—
Total		7	100.0	17	100.0	50	100.0	60	100.0	9	100.0
Average age		39.3		36.0		28.9		29.9		41.3	
Race											
White		11	64.7	14	82.4	36	72.0	47	78.3	7	77.8
Non-white		6	35.3	3	17.6	14	28.0	11	18.3	2	22.2
Not noted		—	—	—	—	—	—	2	3.3	—	—
Total		17	100.0	17	10.0	50	100.0	60	99.9	9	100.0
Sex											
Male		10	58.8	8	47.1	24	48.0	30	50.0	1	11.1
Female		7	41.2	9	52.9	26	52.0	30	50.0	8	88.9
Total		17	100.0	17	100.0	50	100.0	60	100.0	9	100.0
Grade completed											
None		—	—	—	—	1	2.0	2	3.3	—	—
1-7		10	58.8	3	17.6	10	20.0	13	21.7	4	44.5
8		—	—	1	5.9	2	4.0	6	10.0	1	11.1
9-11		3	17.6	5	29.4	11	22.0	10	16.7	1	11.1
12		1	5.9	6	35.3	13	26.0	23	38.3	1	11.1
13-15		3	17.6	1	5.9	2	4.0	2	3.3	1	11.1
16 and over		—	—	—	—	1	2.0	1	1.7	1	11.1
Special Ed.		—	—	1	5.9	10	20.0	3	5.0	—	—
Total		17	99.9	17	100.0	50	100.0	60	100.0	9	100.0

Table 34 (cont.)

Primary Service Rendered	Alamance No.	Alamance %	Davidson No.	Davidson %	Forsyth No.	Forsyth %	Gulford No.	Gulford %	Orange No.	Orange %
Physical Restoration	17	100.0	8	47.1	12	24.0	23	38.3	9	100.0
Job Training	—	—	9	52.9	25	50.0	25	41.7	—	—
Counseling	—	—	—	—	1	2.0	2	3.3	—	—
Placement	—	—	—	—	9	18.0	8	13.3	—	—
Other	—	—	—	—	3	6.0	2	3.3	—	—
Not noted	—	—	—	—	—	—	—	—	—	—
Total	17	100.0	17	100.0	50	100.0	60	100.0	9	100.0
Other Services Rendered	—	—	1	—	6	—	2	—	—	—
Physical Restoration	—	—	1	—	4	—	3	—	1	—
Job Training	16	—	5	—	28	—	29	—	9	—
Counseling	1	—	3	—	6	—	19	—	—	—
Job Placement	—	—	3	—	5	—	10	—	—	—
Other	408.95	—	\$724.28	—	\$444.32	—	\$578.72	—	\$1037.77	—
Estimated Cost of Services (average)	—	—	—	—	—	—	—	—	—	—
6 mos. or less	8	47.0	3	17.6	7	14.0	17	28.3	2	22.2
7-12 mos.	5	29.4	4	23.5	16	32.0	17	28.3	4	44.5
13-18 mos.	2	11.8	4	23.5	10	20.0	9	15.0	1	11.1
19-36 mos.	2	11.8	4	23.5	13	26.0	11	18.3	1	11.1
37 mos. or more	—	—	2	11.8	3	6.0	6	10.0	1	11.1
Not noted	—	—	—	—	1	2.0	—	—	—	—
Total	17	100.0	17	99.9	50	100.0	60	99.9	9	100.0
Median no. Months	7.0	—	13.0	—	14.0	—	10.5	—	11.0	—

Table 34 (cont.)

Weekly Earnings on Last Job Held Prior to Acceptance	Alamance No.	%	Davidson No.	%	Forsyth No.	%	Gulford No.	%	Orange No.	%
Farmers, homemakers, unpaid family Workers, students	4	23.5	10	58.8	22	44.0	25	41.7	7	77.8
Less than \$10 wk.	—	—	—	—	—	—	—	—	1	11.1
\$10-19	—	—	—	—	—	—	1	1.7	—	—
\$20-39	2	11.8	—	—	13	26.0	9	15.0	—	—
\$40-50	4	23.5	5	29.4	9	18.0	14	23.3	—	—
\$60-79	5	29.4	—	—	4	8.0	5	8.3	1	11.1
\$80-over	2	11.8	2	11.8	1	2.0	6	10.0	—	—
Not noted	—	—	—	—	1	2.0	—	—	—	—
Total	17	100.0	17	100.0	50	100.0	60	100.0	9	100.0
Job Status at Acceptance										
Employed	1	5.9	4	23.5	4	8.0	10	16.7	—	—
Unemployed	13	76.5	6	35.3	37	74.0	44	73.4	3	33.3
Household worker (own home)	3	17.6	1	5.9	2	4.0	4	6.7	6	66.7
Other	—	—	6	35.3	7	14.0	2	3.3	—	—
Total	17	100.0	17	100.0	50	100.0	60	100.1	9	100.0
Weekly Earnings at Acceptance										
None	15	88.2	13	76.5	46	92.0	50	83.3	9	100.0
Less than \$10	—	—	—	—	—	—	—	—	—	—
\$10-19	—	—	1	5.9	1	2.0	—	—	—	—
\$20-39	—	—	—	—	2	4.0	2	3.3	—	—
\$40-59	1	5.9	2	11.8	1	2.0	3	5.0	—	—
\$60-79	1	5.9	—	—	—	—	2	3.3	—	—
\$80-over	—	—	1	5.9	—	—	3	5.0	—	—
Total	17	100.0	17	100.0	50	100.0	60	99.9	9	100.0

Table 34 (cont.)

Weekly Earnings at Closure	Alamance No.	%	Davidson No.	%	Forsyth No.	%	Guilford No.	%	Orange No.	%
None	4	23.5	3	17.6	5	10.0	7	11.7	7	77.8
Less than \$10	—	—	—	—	1	2.0	2	3.3	—	—
\$10-19	—	—	2	11.8	—	—	1	1.7	—	—
\$20-39	2	11.8	1	5.9	11	22.0	4	6.7	1	11.1
\$40-59	2	11.8	5	29.4	14	28.0	19	31.7	—	—
\$60-79	7	41.2	1	5.9	10	20.0	14	23.3	—	—
\$80 and over	2	11.8	5	29.4	8	16.0	13	21.7	1	11.1
Not noted	—	—	—	—	1	2.0	—	—	—	—
Total	17	100.1	17	100.0	50	100.0	60	100.1	9	100.0

Table 35
Selected Western North Carolina Counties with High Rehabilitation Rates

Fiscal Year 1967*

<u>Residence</u>	Cherokee		Madison		Mitchell		Swain		Yancey	
	No.	%	No.	%	No.	%	No.	%	No.	%
Rural farm	2	25.0	8	88.9	10	83.3	1	11.1	8	88.9
Rural non-farm	3	37.5	1	11.1	—	—	7	77.8	—	—
Urban	3	37.5	—	—	2	16.7	1	11.1	1	11.1
Metropolitan	—	—	—	—	—	—	—	—	—	—
Unknown	—	—	—	—	—	—	—	—	—	—
Total	8	100.0	9	100.0	12	100.0	9	100.0	9	100.0
<u>Disability</u>										
Mental Illness	—	—	—	—	—	—	—	—	—	—
Mental Retardation	—	—	1	11.1	—	—	—	—	—	—
Physical	8	100.0	8	88.9	12	100.0	9	100.0	9	100.0
Total	8	100.0	9	100.0	12	100.0	9	100.0	9	100.0
<u>Marital Status</u>										
Married	1	12.5	3	33.3	10	83.3	6	66.7	8	88.9
Single	5	62.5	4	44.4	—	—	1	11.1	1	11.1
Divorced	—	—	1	11.1	—	—	—	—	—	—
Widowed	1	12.5	1	11.1	1	8.3	2	22.2	—	—
Separated	1	12.5	—	—	1	8.3	—	—	—	—
Total	8	100.0	9	99.9	12	99.9	9	100.0	9	100.0

*Figures are based on a 20% random sample drawn from the "closed rehabilitated" cases in each county.

Table 35 (cont.)

Age of referral	Cherokee No.	Cherokee %	Madison No.	Madison %	Mitchell No.	Mitchell %	Swain No.	Swain %	Yancey No.	Yancey %
Less than 20 years	2	25.0	1	11.1	—	—	—	—	1	11.1
20-34 years	—	—	3	33.3	4	33.3	2	22.2	4	44.4
35-44 years	4	50.0	1	11.1	3	25.0	3	33.3	—	—
45-64 years	2	25.0	4	44.4	5	41.7	4	44.4	4	44.4
65 and over	—	—	—	—	—	—	—	—	—	—
Total	8	100.0	9	99.9	—	—	9	99.9	9	99.9
Average Age	37.0		37.1		42.7	100.0	42.6		40.2	
Race										
White	8	100.0	9	100.0	12	100.0	8	88.9	8	88.9
Non-white	—	—	—	—	—	—	1	11.1	1	11.1
Total	8	100.0	9	100.0	12	100.0	9	100.0	9	100.0
Sex										
Male	6	75.0	5	55.6	6	50.0	—	—	5	55.6
Female	2	25.0	4	44.4	6	50.0	9	100.0	4	44.4
Total	8	100.0	9	100.0	12	100.0	9	100.0	9	100.0
Grade Completed										
None	—	—	—	—	—	—	—	—	—	—
1-7	5	62.5	5	55.6	7	58.3	5	55.6	3	33.3
8	1	12.5	1	11.1	—	—	2	22.2	1	11.1
9-11	1	12.5	2	22.2	4	33.3	1	11.1	2	22.2
12	1	12.5	1	11.1	1	8.3	—	—	3	33.3
13-15	—	—	—	—	—	—	—	—	—	—
16 and over	—	—	—	—	—	—	—	—	—	—
Special Ed.	—	—	—	—	—	—	—	—	—	—
Not noted	—	—	—	—	—	—	1	11.1	—	—
Total	8	100.0	9	100.0	12	99.9	9	100.0	9	99.9

Table 35 (cont.)

Primary Service Rendered	Cherokee No.	%	Madison No.	%	Mitchell No.	%	Swain No.	%	Yancey No.	%
Physical Restoration	6	75.0	6	66.7	11	91.7	8	88.9	7	77.8
Job Training	2	25.0	2	22.2	—	—	1	11.1	1	11.1
Counseling	—	—	—	—	—	—	—	—	—	—
Placement	—	—	—	—	1	8.3	—	—	—	—
Other	—	—	1	11.1	—	—	—	—	1	11.1
Not noted	—	—	—	—	—	—	—	—	—	—
Total	8	100.0	9	100.0	12	100.0	9	100.0	9	100.0
Other Services Rendered										
Physical Restoration	—	—	—	—	—	—	—	—	—	—
Job Training	—	—	—	—	—	—	—	—	—	—
Counseling	—	—	9	—	12	—	—	—	9	—
Job Placement	—	—	1	—	—	—	—	—	1	—
Other	1	—	1	—	2	—	4	—	2	—
Estimated Cost of Services (Average)		\$467.41		\$337.83		\$372.64		\$197.71		\$381.72
Months from Acceptance to Closure										
6 mos. or less	4	50.0	5	55.6	12	100.0	4	44.4	5	55.6
7-12 mos.	1	12.5	1	11.1	—	—	1	11.1	2	22.2
13-18 mos.	1	12.5	—	—	—	—	1	11.1	—	—
19-36 mos.	2	25.0	2	22.2	—	—	2	22.2	2	22.2
37 mos. or more	—	—	—	—	—	—	1	11.1	—	—
Not noted	—	—	1	11.1	—	—	—	—	—	—
Total	8	100.0	9	100.0	12	100.0	9	99.9	9	100.0
Media no. months	6.5		4.5		3.5		11.0		4.0	

Table 35 (cont.)

	Cherokee No.	%	Madison No.	%	Mitchell No.	%	Swain No.	%	Yancey No.	%
Weekly Earnings on Last Job Held Prior to Acceptance										
Farmers, homemak- ers, unpaid family workers, students	4	50.0	5	55.6	7	58.3	7	17.8	6	66.7
Less than \$10 wk.	—	—	—	—	—	—	—	—	—	—
\$10-19	—	—	—	—	—	—	—	—	—	—
\$20-39	1	12.5	2	22.2	2	16.7	2	22.2	—	—
\$40-59	3	37.5	1	11.1	—	—	—	—	1	11.1
\$60-79	—	—	—	—	2	16.7	—	—	1	11.1
\$80-over	—	—	—	—	1	8.3	—	—	1	11.1
Not noted	—	—	1	11.1	—	—	—	—	—	—
Total	8	100.0	9	100.0	12	100.0	9	100.0	9	100.0
Job Status at Acceptance										
Employed	4	50.0	1	11.1	3	25.0	4	44.4	—	—
Unemployed	4	50.0	3	33.3	3	25.0	1	11.1	4	44.4
Household worker (own home)	—	—	3	33.3	4	33.3	4	44.4	4	44.4
Other	—	—	2	22.2	2	16.7	—	—	1	11.1
Total	8	100.0	9	99.9	12	100.0	9	99.9	9	99.9
Weekly Earnings at Acceptance										
None	7	87.5	8	88.9	9	75.0	7	77.8	9	100.0
Less than \$10	—	—	—	—	—	—	—	—	—	—
\$10-19	—	—	—	—	—	—	—	—	—	—
\$20-39	—	—	—	—	2	16.7	2	22.2	—	—
\$40-59	1	12.5	1	11.1	—	—	—	—	—	—
\$60-79	—	—	—	—	1.8.3	—	—	—	—	—
\$80-over	—	—	—	—	—	—	—	—	—	—
Total	8	100.0	9	100.0	12	100.0	9	100.0	9	100.0

Table 35 (cont.)

Weekly Earnings at Closure	Bertie		Columbus		Martin		New Hanover		Sampson	
	No.	%	No.	%	No.	%	No.	%	No.	%
None	3	37.5	4	44.4	6	50.0	4	44.4	4	44.4
Less than \$10	—	—	—	—	—	—	—	—	—	—
\$10-19	—	—	—	—	—	—	—	—	—	—
\$20-39	1	12.5	2	22.2	3	25.0	4	44.4	1	11.1
\$40-59	2	25.0	2	22.2	—	—	1	11.1	2	22.2
\$60-79	2	25.0	1	11.1	1	8.3	—	—	2	22.2
\$80-over	—	—	—	—	2	16.7	—	—	—	—
Total	8	100.0	9	99.9	12	100.0	9	99.9	9	99.9

REPORT OF COUNSELOR CASELOAD PRACTICE SURVEY

REPORT OF COUNSELOR CASELOAD PRACTICE SURVEY

A counselor survey has been completed. The survey which has been tabulated was a very simple one which was devised primarily to acquaint the study staff with caseload problems as counselors see them and also as a technique for getting acquainted with the field staff of the State agency. In addition to getting survey forms into the hands of the agency's entire field counseling staff, members of the Planning Project visited with the counselors in their particular offices to discuss the North Carolina Study in general and to elicit from them comments and ideas as to how the Study might best benefit them in their casework. Slightly better than 65 percent of the survey forms were returned.

Results

It was anticipated that counselors would probably not be cognizant of the large numbers of referrals that they reject for service. Counselors indicated that they only accepted for service about 61 per cent of the referrals they received. The acceptance rate by the Agency is not quite that good; however, this figure does indicate that the counselor is aware of the large numbers of persons being closed in "08". Reasons the counselors gave for not accepting referrals were as follows in the order which they are given:

1. The person has no disability.
2. The person is too disabled to be feasible for service.
3. The person is unmotivated for rehabilitation services.

A related factor that will be discussed more in depth later is that for the studied 2,752 records of the approximately 5,000 "08" closures completed last year, the Agency spent only an average of \$1.15 per client for diagnosis or service. Although many of these people were probably referred to the Agency accompanied by medical and psychological information, this very small expenditure raises serious questions concerning the thoroughness of the investigation of eligibility before closure in "08" status. Other information from this survey indicates that the counselors feel that the following resources are in shortest supply. The resources are listed in the same numerical order as indicated on the returned survey forms.

1. Academic training
2. Vocational and trade training
3. Psychological evaluation
4. Speech therapy
5. Physical therapy
6. Family maintenance
7. Sheltered living
8. Sheltered employment
9. Transportation
10. Recreation

It is interesting to note that on all the survey forms turned in by counselors last year, not one counselor indicated concern about the amount of case service money available to him. Of course, after this year's

experience of the Agency having to curtail services as a result of money shortages, the same questionnaire would undoubtedly solicit, without exception, concern on the part of the field staff about case service money.

The counselors responded to a request to describe the most difficult cases with whom they had to work by listing these characteristics in the order which they are recorded:

1. Little or no education
2. Poor motivation
3. Unrealistic goals and aspirations
4. Older workers with only manual labor experiences

They further indicated that the personal characteristics which interfered most with rehabilitation were:

1. Dependency
2. Self-pity
3. Poor personal hygiene
4. Immaturity
5. Lack of self-confidence
6. Parental protectiveness

The Agency practices and attitudes most detrimental to effective rehabilitation were listed as:

1. Pressure for production
2. Size of caseload
3. A welfare philosophy
4. Interagency buck passing

Counselors enumerated the following as the most time-consuming aspects of their jobs:

1. Paper work
2. Attending meetings
3. Travel
4. Preparation of reports
5. Bussing clients to and from appointments
6. Counseling and follow-up

Questions regarding the counselor's use of guidance tests were answered to indicate that almost no guidance instruments are used by the counselor in fulfilling his role as a counselor.

This information certainly leads one to the conclusion that the counselor, because of lack of skill or because of the pressure of numbers of people on his caseload, finds it most difficult to work with the cases where one would normally expect counseling to play a major role in the rehabilitation process. Also seen in this information are indications of the need for streamlining and dealing more effectively with administrative problems and this information, coupled with subsequent information received, indicated that the counselors are probably not fully utilizing resources that are presently available to them in the community. A very tentative conclusion is that most of these difficulties are amenable only to increased in-service staff training which must be so structured that it interferes to the least extent with caseload management; also that the Agency probably must begin putting as much effort toward developing administrative techniques as it has into the provision of meaningful service programs.

As a result of visiting the district offices, an awareness was developed that the phenomenal growth achieved by the Rehabilitation Agency in the last five years has been almost entirely in special areas; thereby, giving very little relief to the pressures experienced in serving the general handicapped popu-

lation. Counselors serving the disabled in the general population still may serve tremendous numbers of people and many of them travel huge geographic areas working from their car or in space provided for them by numerous public and private agencies. These counselors are continuing to carry the bulk of the caseload of the Agency and it would seem at this time that there is possibly a need to concentrate on "beefing up" the general rehabilitation program.

Caseload Analysis

In order to plan for strengthening the state's vocational rehabilitation program, it was felt that we needed to carefully study what the State is presently doing for the handicapped segment of our society. For years the North Carolina Agency has been recognized as one of the national leaders in terms of the numbers of people it has served effectively. The state has taken great pride in its position of leadership and by comparing state agency data with national data, there has always been the feeling that North Carolina is doing very well in almost every respect. Persisting questions arise, however, concerning how North Carolina is able to effectively serve larger caseloads of people per counselor and successfully rehabilitate so many people without having an exceptional amount of money and resources with which to work.

RECOMMENDATION

The Governor's Study Committee on Vocational Rehabilitation respectfully submits the following recommendation:

The State of North Carolina should strongly urge and support the further professionalization of its Division of Vocational Rehabilitation.

Presently, the Vocational Rehabilitation Agency has very few professionally trained rehabilitation personnel. University training in rehabilitation, both in this State and the nation, is of relatively recent vintage. Regionally sponsored in-service training programs, although greatly expanded and of high quality, are not meeting the full needs of staff development. Recognizing the ever-increasing demand for manpower in the social services field, it is becoming increasingly clear that the universities or the extra agency training programs can never supply the full professional training needs of the Vocational Rehabilitation Agency.

The Division of Vocational Rehabilitation should expand its in-service training officer's staff to include a qualified training officer for each of the Division's six geographic areas. These people, under the supervision and guidance of the State office, should develop a uniform training program for the State which could be carried out at the district office level through the casework supervisors, the area training officer and resource personnel recruited from the State's university system.

Such a training program, as has been described, could be accomplished without taking the rehabilitation worker away from his field assignments for additional prolonged periods and would have the added advantage of being presented to small, well acquainted groups who should not be hesitant about full participation. It is further felt that great amounts of truly professional training material can be presented and received in such a situation in a short amount of time.

Costs:

1. Professional Personnel	\$ 63,676.00
2. Clerical Assistance	30,066.00
3. Training Materials	5,000.00
4. Travel and Subsistence	12,000.00
5. Consultation	2,000.00
	\$112,742.00
State Share	\$28,185.50

Recommendation

The Governor's Study Committee on Vocational Rehabilitation respectfully submits the following recommendation:

That the State of North Carolina appropriate and/or secure sufficient financial resources to allow for the expansion of district vocational rehabilitation offices to include space (not presently available) for carrying out district office level in-service training programs and group vocational guidance services.

Assuming that it is advisable to approach staff development and improvement through continuous agency in-service training programs, it would seem to be necessary for each district office to have a conference room sufficient in size to comfortably accommodate its immediate and immediately projected full staff. Such space would serve a dual purpose in that it would also be needed for the proposed group guidance program to be carried out by agency psychologists.

Since there are several vast areas of the State served by one district office, it is felt that there would need to be established at least three or four more district offices in order that no agency person would have a great distance to travel in order to participate fully in the proposed in-service training program. It would also be necessary to keep travel distance to a minimum if clients of the Vocational Rehabilitation Agency are to fully utilize and benefit from a group guidance program. There are presently fourteen vocational rehabilitation district offices. None of these offices, at the present, has sufficient floor space to engage in a quality in-service training program or to do group testing and guidance. These offices on the average should probably be expanded by 250 to 350 square feet of unobstructed space. This much space should also be allowed for these purposes in new district offices as they are established.

Cost:

(18 District Offices)	\$18,900.00
State Share	4,725.00

**STUDY OF THE ADMINISTRATIVE LOCATION OF THE STATE
VOCATIONAL REHABILITATION AGENCY**

STUDY OF THE ADMINISTRATIVE LOCATION OF THE STATE VOCATIONAL REHABILITATION AGENCY

A great deal of time has been spent by the Governor's Study Committee of the North Carolina Study on Vocational Rehabilitation regarding the administrative position of the Vocational Rehabilitation Agency in the structure of the state's government. Like most North Carolina citizens, the committee in the early stages of the study did not understand where the Vocational Rehabilitation Agency was located in the state government and the committee felt that clarification of the location was an important first step for their efforts to realistically plan for the strengthening of the state's Vocational Rehabilitation efforts. The committee requested from the planning director of the North Carolina Study, the preparation of a position paper which would describe the agency's present location and the rational for its location. They also requested material regarding alternatives to the present system.

Inadvertently, the planning director, in the material prepared for the committee, did not disguise his own bias regarding the position of the state agency. This lack of discretion created considerable discussion by the agency's administrative body and resulted in the planning director having a frank open discussion with the State Board of Education regarding the purposes of the North Carolina Study and the necessity for the study to look at all aspects of the vocational rehabilitation program. It was emphasized to the State Board of Education that the bias exhibited by the planning director was not meant to be a reflection on the administrative leadership of the Vocational Rehabilitation Agency's executive body, but that it was rather an expression of personal opinion that the Vocational Rehabilitation Agency had grown so large and that the needs that it is being challenged to meet are so great that the agency needed the benefit of an executive group who could devote their full attention and concentrate their entire effort on the further development of the Vocational Rehabilitation program.

Resulting from the above-described meeting with the State Board of Education in which the personal views of the planning director were clearly stated in public discussion, the planning director has taken considerable liberty in trying to influence the Governor's Study Committee to make a recommendation that would comply with his own personal views. The committee, however, has been very cautious about making any radical recommendations in this regard. They have very thoughtfully considered the pros and cons of separate agency status and of the agency remaining in its present position. It is felt that the sincerity and the integrity of the Governor's Study Committee is expressed in their recommendation concerning the position which the Vocational Rehabilitation Agency should hold in state government. The recommendation has been made despite a great deal of pressure to make a more radical decision.

A subcontract was let to Greenleigh Associates, Inc. to do an administrative and organizational study of the State Agency. This study by an independent firm is to be used as a tool by members of this state and of the legislature in further considering the best location for the Vocational Rehabilitation Agency if this problem again becomes the center of discussion.

After much deliberation, the GOVERNOR'S STUDY COMMITTEE RECOMMENDS THAT THE DIVISION OF VOCATIONAL REHABILITATION REMAIN RESPONSIBLE TO THE STATE BOARD OF EDUCATION. THE STATUS OF THE DIVISION, HOWEVER, SHOULD BE INCREASED SO THAT IT WILL RECEIVE ATTENTION FROM THE STATE BOARD COMMENSURATE WITH THAT PRESENTLY GIVEN THE DEPARTMENT OF PUBLIC INSTRUCTION AND THE DEPARTMENT OF COMMUNITY COLLEGES.

POSITION OF THE DIVISION OF VOCATIONAL REHABILITATION WITHIN STATE GOVERNMENT STRUCTURE*

On January 25, 1967, Undersecretary of Health, Education and Welfare, Wilbur J. Cohen, delivered an address to Statewide Planners for Vocational Rehabilitation. In his speech, "Social Planning for the Coming Decade," Mr. Cohen outlined the social, medical and economic problems faced by the uneducated, poverty stricken, elderly and disabled citizens in our country. Contrary to what one might think, his talk was quite encouraging because it demonstrates an optimism which is presently felt by our socially concerned national leaders concerning our potential to solve social problems. According to Mr. Cohen, the Gross National Product has grown to the point where he could state with confidence, "We have the wealth, the talent and the determination today to successfully cope with and solve the problems (social) that have persisted for centuries." He further stated that *our challenge for the future is to develop an organization capable of bringing our resources to bear on problems where they exist.*

The social welfare field may be one of the last fields to develop an appreciation for the importance of organization. Business and industry learned long ago that success or failure is dependent on organizational efficiency. Indeed, we have won our wars, plummeted with rockets the moon and Venus, and have measured the temperature of Mars because of our technical ability aided by proper organization.

The achievement of North Carolina's desire for "total development", is dependent upon our ability to organize structures with the potential for encompassing both our obvious and poorly defined social ills. If the Vocational Rehabilitation Agency and other resources dedicated to rehabilitation efforts are to play a vital part in the human and economic development of our State, we must be constantly concerned with the organizational structures and relationships with which we have to work. Our initial task in social planning is to examine and evaluate the tools at our disposal for handling the problems with which we are concerned.

The Vocational Rehabilitation Agency presently is located in the Department of Public Instruction which is subject to the administrative control of the State Board of Education and the leadership of the State Superintendent of Public Instruction. This is a traditional location for vocational rehabilitation in State Government. A recent poll of the fifty states, to which thirty-eight states responded, indicated that vocational rehabilitation is in the Department of Education in all but eleven of the states. Six states reported having separate Departments of Rehabilitation and five states indicated that the Vocational Rehabilitation Agency was under some other form of Governmental organization. One state has vocational rehabilitation located within the Department of Health and Welfare. Since the public rehabilitation program was originally limited to retraining persons, largely orthopedically handicapped by industrial accidents, it was natural for the program to begin as an extension of public education. The first legislation authorized the agency responsible for vocational education permission to develop rehabilitation programs at the state level.

Because the earliest pioneers of the rehabilitation movement were vocational educators, the first clients strictly physically handicapped and the first services limited to training around the handicap followed by industrial placement, the program was legitimately placed within education. However, service responsibilities increased to the extent that the agency is no longer primarily educational. Not

*Paper prepared at the request of the Governor's Study Committee for their orientation as to the administrative location of the Division of Vocational Rehabilitation.

included in the original legislation are services which include medical diagnosis, medical treatment and surgery, hospitalization, prosthetic appliances, psychiatric care, speech correction, occupational therapy, maintenance, transportation, training tools and supplies and occupational equipment. One might say that legislative concepts of needs and rehabilitative services grew more rapidly than concepts among administrators. For example, the 1943 legislature authorized the mentally retarded and mentally ill as eligible for services, but it was not until the 1954 legislature reiterated congressional intent that these groups should be served that the agencies began a serious effort to program for them. To be fair, however, it must be said that additional programming was seriously limited because of a shortage of funds. The 1954 legislation appropriated additional federal funds which placed a priority on and made possible the development of programs for the mentally handicapped. Although lack of money is a partial explanation for the slow progress of program implementation, there does seem to be a general consensus among rehabilitation professionals that resistance to changing our first orientation must bear partial responsibility for our failure to move ahead more rapidly.

Resistance to change is characteristic of man and gains in strength as individuals become formed into a society. Therefore, we should issue no indictment of past rehabilitation administrative bodies for failure to provide leadership necessary for dynamic program changes. *For, after all, how much responsibility can a person or a group of individuals take and still be able to focus their creative imagination on specific problems?* Although the position of the State Board of Education and the Department of Public Instruction can be understood as it relates to the Vocational Rehabilitation Program, should we be satisfied to leave with that group responsibility for our rehabilitation program? To concentrate on the multiple problems directly associated with public school programs is in and of itself a super-human task. Too much cannot be said for the stability that education and educational boards have provided the rehabilitation programs in our state and nation; however, it may be that as our society has become more complicated and specialized, we should relieve these people (Boards of Education) of part of their burden, thereby giving them more time for primary duties and giving rehabilitation the advantage of having a board with specific vocational rehabilitation responsibility. *Unless the mission of the Rehabilitation Agency is changed—and this possibility will be explained later—we should separate the agency from the Department of Public Instruction.*

Some of the specific problems associated with the Agency's position in the Department are related to the fact that the Department of Public Instruction is primarily an administrative agency and the Division of Vocational Rehabilitation has a service delivery function. Earlier in this paper the shortage of money for rehabilitation was mentioned. For years now, the Federal Congress has been much more generous in appropriating funds for rehabilitation than have State Legislatures. This may reflect a greater concern at the Federal level for people programs or it may be that lobbying at the national level by groups such as the *National Rehabilitation Association* is more concentrated and effective. At least reports by North Carolina legislators make this seem probable by their statements to the effect that the State Legislature was not made aware of rehabilitation needs nor the amount of federal money being lost because of insufficient state appropriations. Another fact which might be a factor in our financial problems is the impression held by great numbers of people that our rehabilitation agency is "made of money". This idea has developed under the influence of press coverage which almost invariably mentions vocational rehabilitation as a funding agency for local program units. With coverage almost limited to this, the public cannot visualize Vocational Rehabilitation as anything but rich. Also, because our state's statistics for vocational rehabilitation are so favorable in comparison to the national scene, there is a tendency for us to be complacent in considering budget requests which would allow for expansion and growth. An independent agency, or board with specific responsibility for rehabilitation, should certainly be able to more adequately represent the agency to the legislature than a group whose concerns about specific programs are diluted by virtue of their broad range of interest. At least this kind of change would make it impossible for the legislature to indicate a lack of knowledge concerning the agency's needs.

In an attempt to compensate for a shortage of directly appropriated state funds and because cooperation and coordination have assumed the proportion of a major virtue, the Vocational Rehabilitation Agency has entered into cooperative programs with other agencies. Cooperative programs presently

exist with the Department of Mental Health, Department of Corrections, Juvenile Corrections, local school boards and the Department of Public Welfare. In these cooperative programs the other agencies put up money and/or services in kind which then makes possible for the Division of Vocational Rehabilitation to claim a portion of the available federal allocation which cannot be matched by the direct appropriations received from the state. In theory, the rehabilitation agency is supposed to have complete supervisory control of all aspects of these programs. This theory cannot be operational because cooperation implies joint control and authority. Program efficiency suffers in these operations because each agency must attempt to maintain its identity. Just as people operate from their own peculiar frame of reference, agencies also must do the same. The following charts indicate that in the past seven years we have reached a point of diminishing returns for our investments in rehabilitation while still maintaining a position of excellence in relation to the rest of the country.

Data from North Carolina Division of Vocational Rehabilitation

Figure 19. Number of Rehabilitated Clients: N.C., 1960 and 1967

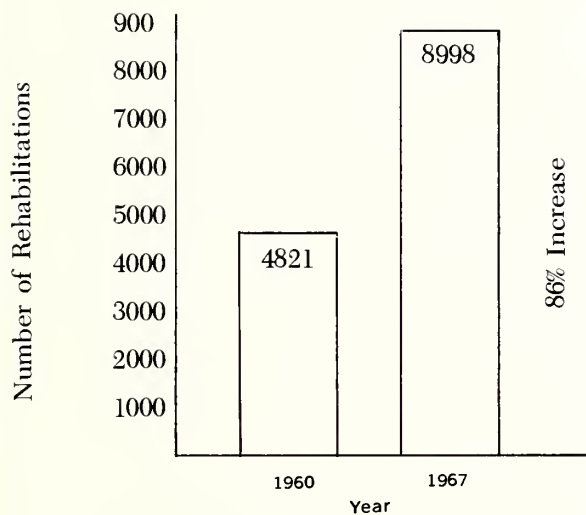


Figure 20. Number of Professional Persons in the Field (Counselors and Supervisors)

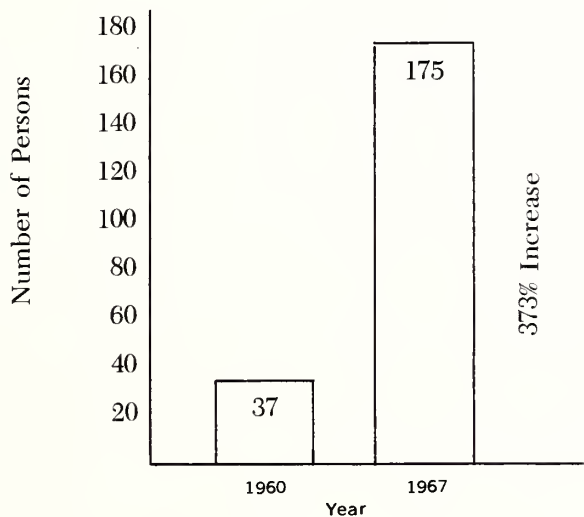


Figure 21. Average Number of Rehabilitations per Professional Persons in the Field

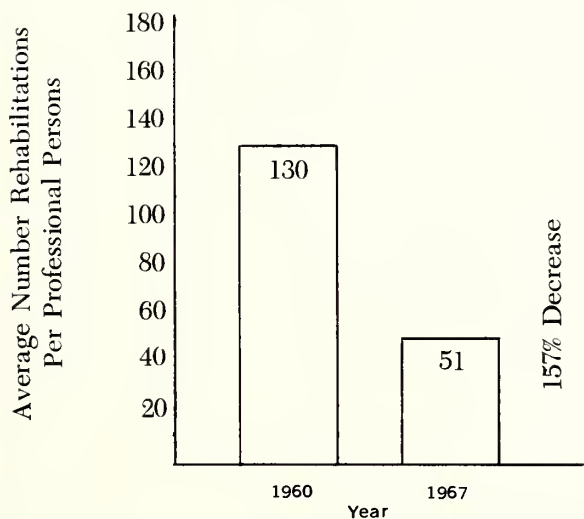


Figure 22. Number of Non-Clerical Support Personnel

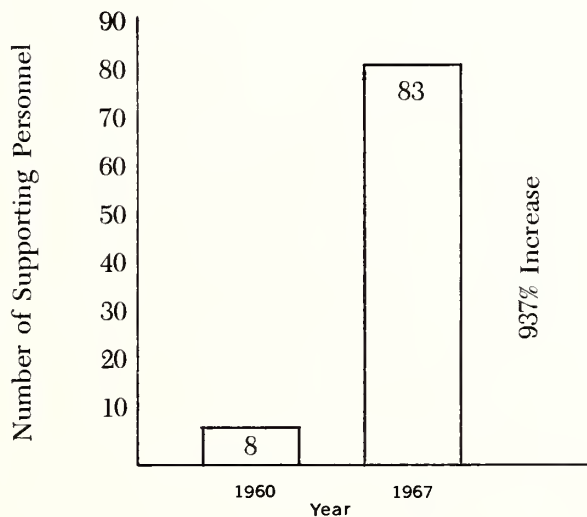


Figure 23. Total Expenditures of N.C. Division of Vocational Rehabilitation, 1960 and 1967

Figure 23

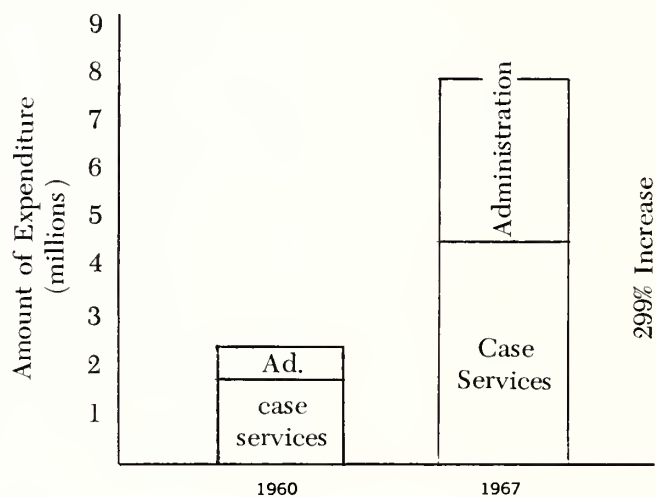
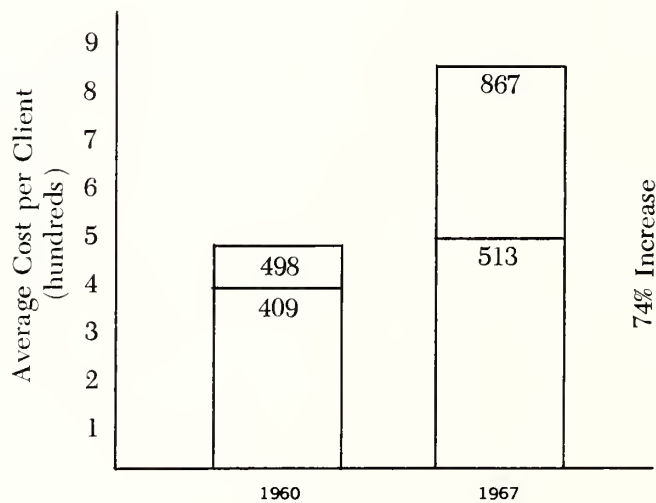


Figure 24.



Data from North Carolina Commission for the Blind

Figure 25. Number of Rehabilitated Clients: N.C., 1960 and 1967

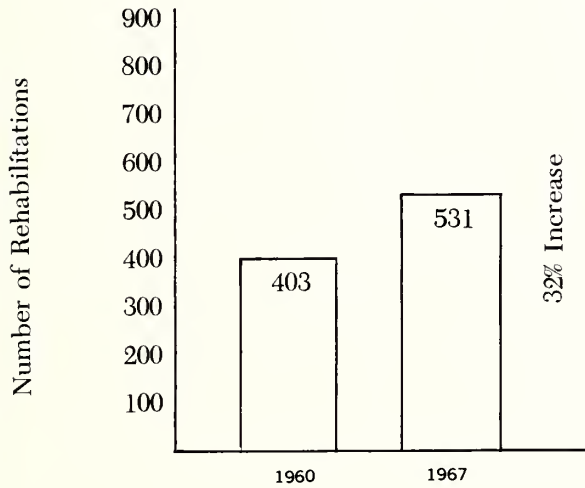


Figure 26. Number of Rehabilitation Counselors and Supervisors in the Field

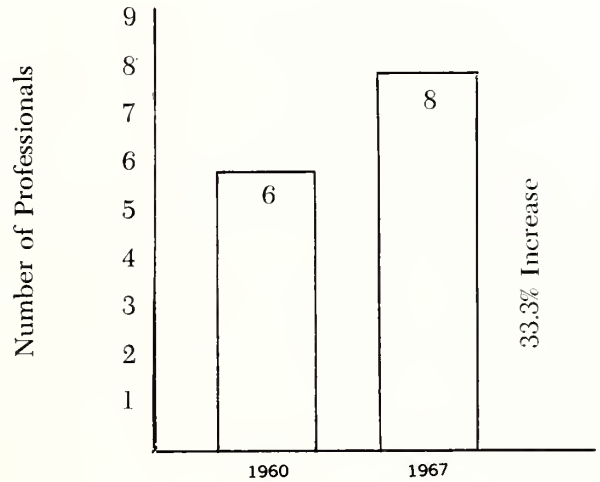


Figure 27. Average Number of Rehabilitations per Professional Person

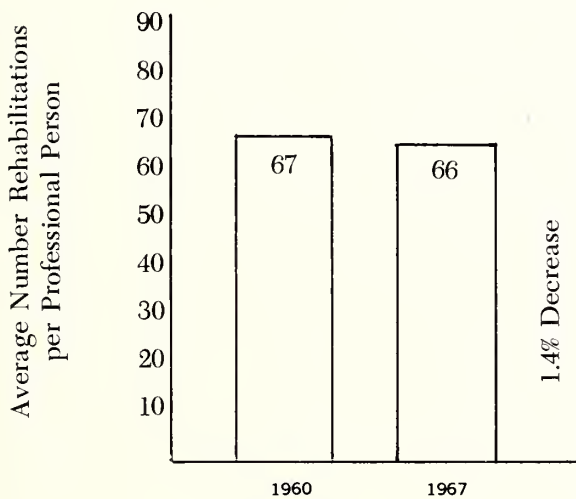


Figure 28. Number of Non-clerical Support Personnel

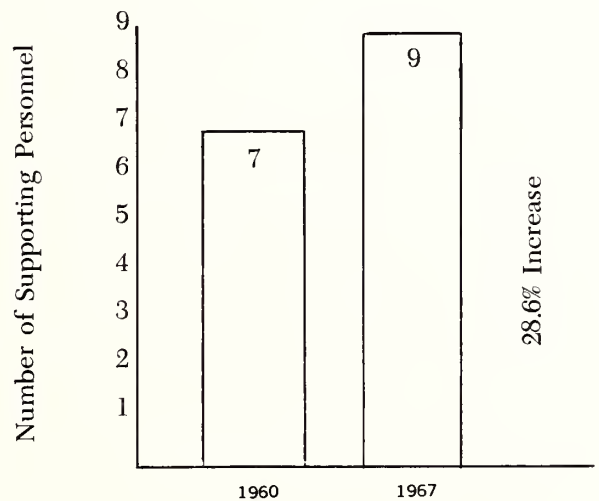


Figure 29. Total Expenditures of North Carolina Commission for the Blind, 1960 and 1967

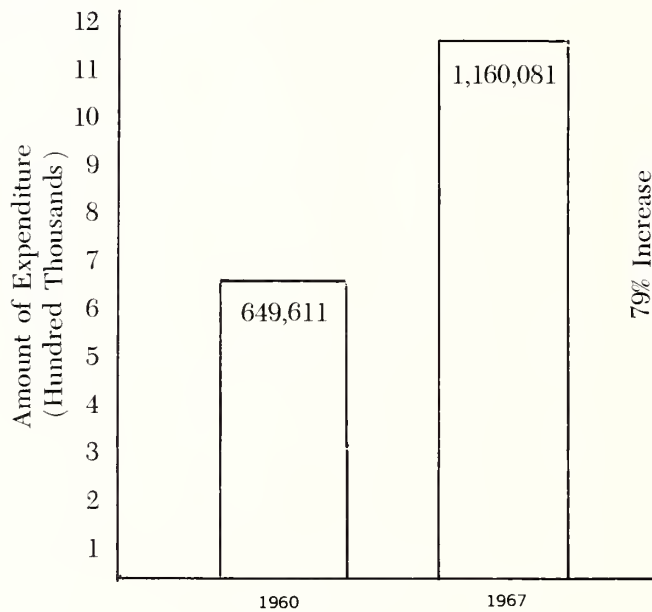
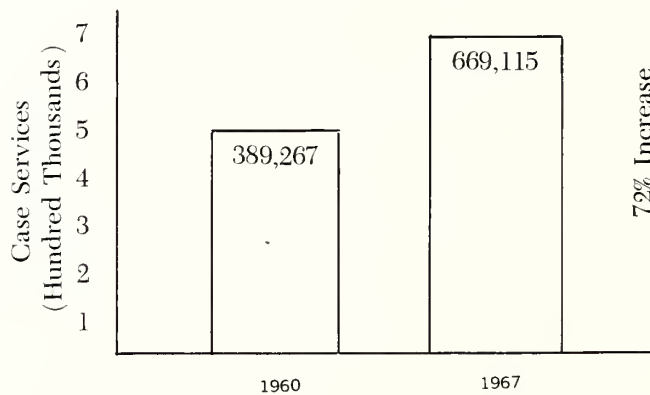


Figure 30. Case Services



Declining results may be caused at least partially by our lack of attention to organization and the inefficiency of cooperative programs. The Commission for the Blind has maintained a constancy which may indicate the advantage of independent operations.

One might be inclined to reason that the decline in functional efficiency results from the fact that the Agency is now serving more severely disabled individuals. This may be, but the average length of time required for rehabilitation has remained relatively constant and the average education of clients at the time of acceptance has jumped from seventh to eighth grade since 1960. The Agency also now has so many more resources at its disposal for helping its clients that we should question whether severity of handicap is the prime reason for our loss of efficiency. Of course, there have been considerable changes in the cost of living index but not enough to account for the discrepancies between 1960 and 1967 Agency data.

There are several alternative positions in state government presently available to the Vocational Rehabilitation Agency according to federal guidelines. The first is our present position previously discussed. The second permissible position is an independent agency legally constituted by state law. A third possibility is divisional status in an agency with health, welfare and or employment service orientation. In any organization, the agency must enjoy equal position with all other divisions. It would be well for us to examine all alternatives. It must be borne in mind, however, that all implications cannot be explored in the confines of this paper.

If the Vocational Rehabilitation Agency were to assume the position of an independent body, the State Legislature would first have to legally create the service. Today, the program is simply a permissive service with no legal base in this State. Such an agency, if worthwhile, should receive from the state direct appropriations of all money presently allocated for vocational rehabilitation purposes plus an additional amount as needed to match sufficient federal funds needed to do the job of vocational rehabilitation. This would represent not only the funds presently received by the Division of Vocational Rehabilitation, but also funds appropriated to cooperative agencies which presently come to the Vocational Rehabilitation Agency indirectly. Such an organization should then build whatever specialty programs needed for the rehabilitation of clients referred by other specialized agencies. These programs should be geographically separated from public schools and mental health institutions. There should also be district or regional "boards of control" with legally constituted authority to direct and supervise the development of programs at the local level, thereby making vocational rehabilitation a local issue. Programs could then avoid orientational conflicts of dual agency administration.

Another possibility would be the creation of an agency offering a constellation of services of which vocational rehabilitation would be a division. Since rehabilitation is the highest goal of most people programs, perhaps the state should organize according to the federal model; a Social and Rehabilitation Services Administration. In this organization a central administration would design all service programs to treat each client as a whole person rather than a fractionated series of specialized needs. Such an approach should have the advantage of assisting the state in the development of a comprehensive, consistent philosophy regarding desirable goals for state services.

One other possibility which might have merit would be to divide rehabilitation service money and responsibility among our specialized agencies. To do this would amount to the creation of numerous divisions of vocational rehabilitation, each with specialized interest and orientation. This Division of Vocational Rehabilitation's responsibility would create within each agency an awareness of the need for sequential programs leading to the most complete development of its individual clients. As soon as closed rehabilitation cases became important to the agency, it would naturally attempt to redesign its programs so that every phase would have rehabilitation value. The present Division of Vocational Rehabilitation could appropriately stay with the Department of Public Instruction or in the Community College Program. The agency's service responsibility would be limited to those disabled who fall outside the purview of special group agencies. It could function as a consultative body to other agencies who would be developing their own vocational rehabilitation programs while at the same time acting as an in-service training agency devoting itself to developing and strengthening manpower needed by service programs. Another function, the importance of which has often been overlooked, is continuous

research regarding rehabilitation evaluations, methods and procedures. The present agency could concentrate in this area of research.

A great deal of effort will be required to identify all the implications, the strengths and weaknesses of each approach. It is hoped, however, that with this paper to establish parameters of possibilities and to stimulate your own thoughts that you will begin formulating ideas for discussion. We have the responsibility of an important undertaking and our decisions may have far reaching effects. We can play safe and limit our activities to discussion, but to fail in the development of firm recommendations is to fail our purpose and the disabled presently being missed by our service programs.

REPORT ON ARCHITECTURAL BARRIERS SUBCOMMITTEE

One of the members of the Governor's Study Committee of the North Carolina Study in Vocational Rehabilitation who is a member of the North Carolina General Assembly sponsored legislation in the 1967 session of the Legislature to adopt a law dealing with the removal of architectural barriers from all public buildings. This legislative effort did not get reported out of committee so that it could be considered by the General Assembly as a whole, therefore, the legislative effort failed.

As a result of the legislative effort, however, and considerable ground work done by the subcommittee of the Governor's Study Committee on Architectural Barriers, a hearing was held before the State Building Code Council regarding the Council's adoption of an Architectural Barrier Code. There was considerable interest in this hearing generated by the Subcommittee on Architectural Barriers, therefore, the hearing was very well attended. Numerous presentations were made at the hearing and the presentations were of such quality that they resulted in the adoption by the Building Code Council of the American Architectural Standards Code. It is felt that this is one tremendous concrete achievement that the North Carolina Study in Vocational Rehabilitation was at least partially responsible for.

One very important concern remains about the Architectural Barriers Code. That concern is in relation to its enforcement. Therefore, a recommendation is being submitted which may provide the means by which the code adopted by the state Building Code Council, can be carried out. (See administrative recommendation 11).

SPECIAL COMMENDATIONS ARE APPROPRIATE FOR INSURANCE COMMISSIONER EDWIN S. LANIER WHO APPEARED AT THE HEARING AND TESTIFIED QUITE EFFECTIVELY AND ELOQUENTLY REGARDING THE BENEFITS WHICH WOULD ACCRUE THROUGH THE ELIMINATION OF ARCHITECTURAL BARRIERS. GRATITUDE IS ALSO EXPRESSED TO THE MEMBERS OF THE NORTH CAROLINA BUILDING CODE COUNCIL FOR THEIR ATTENTIVENESS DURING THE HEARING AND THE EMPATHY FOR PERSONS WITH LIMITATIONS OF MOBILITY DEMONSTRATED BY THEIR ACTION. AS THE DEPARTMENT OF INSURANCE ASSIST IN THE FUTURE ENFORCEMENT OF THIS SECTION OF THE STATE CODE THE DISABLED IN THIS STATE SHOULD FEEL INCREASINGLY GRATEFUL TO THE DEPARTMENT.

**REPORT OF EFFORT TO BRING
VOCATIONAL REHABILITATION
TO THE ATTENTION OF CANDIDATES
FOR PUBLIC OFFICE**

REPORT OF EFFORT TO BRING VOCATIONAL REHABILITATION TO THE ATTENTION OF CANDIDATES FOR PUBLIC OFFICE

Since various activities of the North Carolina Study in Vocational Rehabilitation have led to the conclusion that the Vocational Rehabilitation Agency is an unknown quantity to the general public and public officials, we secured a list of names of all candidates for local, state and national offices from the North Carolina Secretary of State. Using this as a mailing list, a letter was prepared and sent to all candidates over the personal signature of Mrs. James H. Semans, Chairman of the Governor's Study Committee on Vocational Rehabilitation. In this letter we informed the candidates of the North Carolina Study in Vocational Rehabilitation, presented them with some of our preliminary findings, gave them a resume of the social and economic value of vocational rehabilitation services to citizens of this State, and provided them with information regarding the vast numbers of people in our State population who have some degree of handicap because of physical, social, mental and emotional disabilities. The letter tried to stress that the handicapped and disabled constitute a large segment of the constituency which every public official represents and serves. The letter also indicated a willingness to provide any interested candidate with more detailed information if he felt that it would help him in devising campaign plans or formulating his ideas for programs if elected.

Results

From the approximately five to six hundred letters to candidates which we mailed out, we got many responses thanking us for the information which we had sent and stating that at some future time they would like to discuss rehabilitation services more fully with someone from this staff. There was not a large number of requests for additional information immediately but the number was gratifying. Through these contacts and through continuing contacts with key members of the Legislature who are involved, in one way or another with various aspects of the North Carolina Study in Vocational Rehabilitation, we are continuing to get feedback that members of the Legislature are better aware of and more conscious of the needs and benefits of vocational rehabilitation than at any other previous time. Several key legislators have stated that vocational rehabilitation will certainly be placed in a position to receive more legislative attention during the next session than it ever has before.

REPORT ON TRANSPORTATION PROBLEMS

The North Carolina Mental Health Planning Study completed in 1965 indicated that in some sections of the state there are tremendous problems of transportation that have a particular effect on the disabled and handicapped. The public hearings held by the North Carolina Study in Vocational Rehabilitation in the western most parts of the state and in the far east areas of the state confirmed that there is a great concern regarding the lack of adequate public transportation. Since mobility is a part of American life which is taken for granted by most people, the problems imposed by limited mobility are sometimes difficult to comprehend but it was the consensus of many persons giving testimony at the public hearings that transportation difficulties sometimes are a definite impediment to the rehabilitation of disabled people. Because of this fact, a recommendation has been prepared regarding the development of diagnostic centers which would make it possible for persons from inaccessible areas to receive complete diagnosis as the result of making one trip. (See case service recommendation 24)

CHAPTER V
THE COMPOSITE WORKING PLAN

Table 36

Total Projected Need and Cost¹ of Needed Services, by Disability
(Expenditures and Cost in Thousands of Dollars)

CATEGORY	Estimated Coverage by Present Programs Fiscal Year 1968			Fiscal Year 1970		Fiscal Year 1975	
	Number Served	Expenditures	Average Cost per Client*	Number in Need ²	Cost ¹ Need ²	Number in	Cost ¹
VISUAL IMPAIRMENTS:	2,615	\$1,363	\$521.37	39,550	\$ 21,857	41,540	\$ 26,206
Blind (Commission for the Blind)	2,015	\$1,062	\$527.23†				
Other	600	\$ 301	\$501.71				
HEARING IMPAIR- MENTS:	716	\$ 146	\$203.60	28,980	\$ 6,254	30,650	\$ 7,551
ORTHOPEDIC IMPAIRMENTS:	3,483	\$1,755	\$503.77	302,390	\$161,475	319,120	\$194,523
Three of more limbs	308	\$ 232	\$751.43				
One upper, one lower limb	259	\$ 110	\$424.09				
One or both upper limbs	513	\$ 195	\$380.56				
One or both lower limbs	1,443	\$ 842	\$583.44				
Other	960	\$ 376	\$391.87				
ABSENCE or Amputation of LIMBS	448	\$ 203	\$452.03	38,680	\$ 18,534	40,830	\$ 22,332
MENTAL DISORDERS:	7,512	\$1,680	\$223.65	64,220	\$ 15,225	68,220	\$ 18,461
Psychotic Disorders	1,194	\$ 340	\$285.11				
Neurotic Disorders	393	\$ 147	\$375.21				
Drug Addiction	12	\$ 4	\$356.30				
Alcoholism	632	\$ 85	\$133.69				
Personality Disorders	456	\$ 115	\$251.75				
Mental Retardation (Mild)	3,970	\$ 596	\$150.15				
(Moderate)	657	\$ 306	\$465.26				
(Severe)	198	\$ 87	\$438.73				
LEUKEMIA and OTHER CONDITIONS RESULT- ING from NEOPLASMS	158	\$ 38	\$242.53	15,540	\$ 3,995	16,120	\$ 4,731
ALLERGIC, ENDO- CRINE SYSTEM, METABOLIC &- NUTRITIONAL DISEASES	762	\$ 375	\$492.52	34,970	\$ 18,257	37,100	\$ 22,110
DISEASES of the BLOOD	58	\$ 19	\$324.58	3,050	\$ 1,049	3,250	\$ 2,276

*The average cost was figured by using the exact case service expenditure, rather than the rounded figure in column two (2).

¹ These figures were obtained by multiplying the number in need by the average case service cost per client and adding to this a 3% per year increase to account for increases in cost of living (based on cost of living index trends over the past 5 years).

² This figure was obtained by multiplying the estimated number of disabled persons in N. C. (as found in the population survey) by the percent of persons accepted by the agency in each of the disability categories. It is felt that these rates are inaccurate because such a large number of "08" cases were not identified by disability, thus there is no way of determining the categories in which these unidentified cases should have been included

† Included in this figure are operational costs of the Rehabilitation Center.

Table 36 (cont.)
Total Projected Need and Cost¹ of Needed Services, by Disability
(Expenditures and Cost in Thousands of Dollars)

CATEGORY	Estimated Coverage by Present Programs Fiscal Year 1968			Fiscal Year 1970		Fiscal Year 1975	
	Number Served	Expenditures tures	Average Cost per Client [*]	Number in Need ²	Cost ¹ Need ²	Number in	Cost ¹
DISORDERS of							
NERVOUS SYSTEM	358	\$ 128	\$357.53	1,870	\$ 709	1,930	\$ 835
CARDIAC & CIRCULA-							
TORY CONDITIONS	926	\$ 331	\$356.97	115,920	\$ 43,863	122,160	\$ 52,765
RESPIRATORY							
DISEASES	600	\$ 108	\$180.69	23,010	\$ 4,407	24,630	\$ 5,385
DISORDERS of the							
DIGESTIVE SYSTEM	834	\$ 176	\$211.20	26,600	\$ 5,955	28,270	\$ 7,224
CONDITIONS of							
GENITO-URINARY							
SYSTEM	637	\$ 149	\$233.63	17,870	\$ 4,425	19,050	\$ 5,385
OTHER	699	\$ 237	\$339.59	55,300	\$ 19,906	58,510	\$ 24,042
TOTALS for ALL							
CATEGORIES	19,806	\$6,708	\$338.69	767,950 ¹	\$325,911	811,380 ³	\$392,826 ²
CORRECTED TOTALS	19,806	\$6,708	\$338.69	524,464	\$188,289	554,022	\$227,046

¹ Because of the inaccuracy of the data available on the general program in the state, we used the acceptance rate of 46.3% reported by the National Rehabilitation Association (**Highlights of National Studies at 90 State Vocational Rehabilitation Agencies by the Patterns of Rehabilitation Services Project**, Washington, D.C., 1965). Based on this acceptance rate, the total number in need in 1970 and 1975 and the corresponding costs would be those indicated in the last line of the table.

² These figures indicate the estimated total number of persons who will be served by the agency between now and 1975 and the cost of serving these people if all the state's disabled population are served by that time. Thus, the cost figure should be divided by 7 to determine the yearly budget that will be needed if this goal is to be reached.

As can be seen by the preceding charts, a vocational rehabilitation program sufficient to meet the needs of the entire estimated population with rehabilitation needs will require an expenditure of approximately \$32,435,000 per annum between now and 1975. These figures seem quite excessive when compared with what is presently being spent. This year, the Vocational Rehabilitation Agency in its B Budget request which is approximately a 100 per cent increase over its present budget, has requested case service funds in the amount of \$12,034,379. It can be readily seen that to meet the state's total need, will cost approximately three times as much per annum as the amount which has been requested in the B Budget. In the event that the Agency's B Budget request for this year is approved at its present level, there is an automatic implication that the annual cost for rehabilitation will go up in direct proportion to the differential between the budget for the next biennium and the requested budget if the agency is to reach its goal of providing services to everyone who needs them by 1975.

The estimated cost of an adequate vocational rehabilitation program is not excessive, however, when viewed in full prospective. As has been previously pointed out in this report, the estimated state population needing rehabilitation services is approximately 4.5 times greater than earlier estimates regarding the prevalence of disability. The need for increased expenditure again becomes less alarming when it is realized that an estimated 300 per cent increase in service cost should result in a 450 per cent increase in the number of people served by vocational rehabilitation each year.

It is necessary to point out, however, that the increased case service cost does not represent the entire cost for the development of an adequate Vocational Rehabilitation Agency program. It does not include the increased expenditures needed to strengthen the administrative support function of the Agency nor does it include the cost of an intensified in-service training program for Agency personnel nor the need for increasing present salary levels in order to attract and hold persons with better pre-service training and experience. There are other factors involved in the development of an adequate vocational rehabilitation program that are not reflected in the projected cost increase. These are:

1. More thorough psychological diagnosis of all referrals to the Vocational Rehabilitation Agency
2. The development and utilization of specialized facilities which will be necessary to have an adequate program for the seriously multi-handicapped person in our population
3. The creation of a unit to do continued practical and theoretical research to find answers to problems which have prevented efficient and effective program operation and which have prevented the successful rehabilitation of many disabled groups and other seriously impaired individuals.

The projected need for additional case service funds is contingent upon the Vocational Rehabilitation Agency *serving the same type population* it has traditionally served and providing for this expanded group the same basic services at the *same cost*. If the agency is to make its services available to this increased number it must be recognized that the population will *not be the same*. Some will have more severe disabilities which will require services through specialized facilities or techniques. Examples of these persons would be the persons seriously handicapped by a spinal cord injury who can only be rehabilitated through the resources of a comprehensive rehabilitation center or the individual with chronic kidney failure who needs the very costly treatment of kidney dialysis. Also, the persons who have not been served but whose needs are those which have been traditionally provided by Vocational Rehabilitation represent a different population. These individuals must be found and identified through an active well-structured case finding process (outreach). They will also need more complete psychosocial diagnosis and more intensive counseling and guidance service before they will commit themselves to the rehabilitation process.

The cost of rehabilitating people in facilities has not been adequately determined by this Study. Evidence has been collected however, indicating the need for a state-wide system of rehabilitation centers. This need has been confirmed by the facilities advisory committee appointed recently by the Vocational Rehabilitation Agency. This committee concurs with the Study that there is a definite need for a center located in the Durham, Chapel Hill area and that specific plans should be made for this facility by the Agency, Duke and U.N.C. Medical Centers and community colleges. Cost of service can be determined during the planning process.

Other costs which *must be met immediately* for the development of a rehabilitation system to meet the needs of our state are:

1. Center planning (Specific)	\$ 19,000
2. Mobile evaluation Units (Hearing and Vision)	22,000
3. Additional field staff and offices	1,077,000
4. Expanded in-service training	112,742
5. Expanded district offices	18,900
6. Psycho-social diagnostic service	144,000
7. Continued research and planning	70,000
Total	<u>\$1,634,642</u>

The proposed case service budget plus these additional administrative and service costs amount to \$34,069,642. The cost figures for basic administration are not included in the above figure. Assuming this cost could be met by the basic federal-state matching formula, the state would need to appropriate to the Vocational Rehabilitation Agency \$6,813,929.

Other factors will certainly offset the increasing cost of Vocational Rehabilitation. If it is expected that Vocational Rehabilitation is going to expand in an effort to create a more healthy society in our state, it is reasonable to expect that other social programs will be expanding simultaneously. Such programs include:

1. Expanded maternal and child-care programs
2. Early identification of disabilities
3. A strengthened Crippled Children's Program
4. Further development of public education programs so that they will provide more individualized service according to the needs of individual students
5. The evolutionary progress of civil rights programs which tend to reduce social and cultural handicaps.

Assuming that all of these programs are expanded and strengthened at the same time the Vocational Rehabilitation program is being "beefed up", the state can reasonably expect fewer numbers of people handicapped by developmental conditions. One additional factor—the result of which cannot be assessed at the present time in terms of its affect on the expenditures needed for vocational rehabilitation—is the development and adoption of the Title 19 (Medicaid) program. This program may substantially reduce the medical and surgical expenditure presently expected from the agency.

The implications of the foregoing discussion are that there is obviously insufficient data available to make a precise estimate of the expenditures which will be required to meet the goal of providing vocational rehabilitation services to all eligible persons by the year 1975. It should be emphasized, however, that the cost estimates indicated on the charts on pages 289 and 290 are probably conservative estimates but the degree of conservatism cannot be accurately assessed. Even supposing the development of the effectiveness and the efficiency of the other social programs which have been mentioned as preventing developmental handicaps, those persons that the Vocational Rehabilitation Agency will be called on to serve will undoubtedly need more intensified service than those who are being presently served. The cost of purchased services may show a relative decline but with a growing emphasis on counseling and guidance, which is very time-consuming if correctly provided, the average cost per rehabilitation will probably increase at a greater rate than the 3 per cent used in calculating the figures for our charts.

Table 37

Public Rehabilitation Facilities

Category	Present				FY 1970				BY FY 1975			
	Number Facilities	Number Clients	Number Facilities	Number Clients	Number Facilities	Number Clients	Cost	Number Facilities	Number Clients	Cost		
Vocational Rehabilitation Regional Mental Health Facilities	5	4,500	FY 69 (3)	6,000	(5) 2	12,000	1,700				2,500	
Vocational Rehabilitation Local Mental Health Centers	1	250	2	600	10	2,500	60				200	
Vocational Rehabilitation Correctional Rehabilitation Facilities	1	80	FY 69 1	350	5	7,000	600				2,500	
Vocational Rehabilitation Evaluation and Work Adjustment Centers	0	0	2	2,500	4	9,000	1,000				2,000	
Vocational Rehabilitation Facilities for the Deaf	0	0	1	400	1	950	120				750	
Regional Comprehensive Vocational Rehabilitation Center	0	0	0	0	2	3,000	0				5,000	
Vocational Rehabilitation Facilities in Public Schools	32	4,500	40	7,500	50	14,000	50				1,500	
Rehabilitation Center for the Blind	1	110	0	120	(1)	200	0				500	
Rehab. Components Within Public General Hospitals	1	150	0	150	5	2,000	0				5,000	
Rehab. Components Within TB Sanatoriums	3	300	0	325	3	1,800	0				500	
Total Public Facilities	44	9,890	49	17,945	88	52,540	3,530				20,450	

Table 38
Private Rehabilitation Facilities

Category	Present				FY 1970				BY FY 1975			
	Number Facilities	Number Clients	Number Facilities	Number Clients	Number Facilities	Number Clients	Cost	Number Facilities	Number Clients	Cost	Number Facilities	Cost
Sheltered Workshops (blind and general)	40	2,400	(10)	3,000	(10)	3,000	500	(10) 60	15,000	2,500		
Speech and Hearing Facilities	13	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Rehabilitation Components in Private General Hospitals	0	0	1	N/A	N/A	N/A	N/A	N/A	N/A	N/A		
Regional Comprehensive Rehabilitation Centers	3	1,800	(2)	3,000	(2)	3,000	1,000	(2)	4,000	2,000		
Rehabilitation Homes (Half-Way Houses)	6	180	4	300	4	300	200	4	700	250		
Total	62	4,380	17	9,300	17	9,300	1,700	76	19,700	4,750		
Grand Total Public and Private Facilities	106	14,270	66	27,245	66	27,245	5,230	164	72,240	25,200		

NOTES: 1. N/A—not available
2. Parentheses means expansion of existing facility.
3. Cost for establishment only, reported in thousands.

The preceding charts regarding the future development of workshops and facilities were prepared by the Workshop and Facilities Planning personnel in the North Carolina Division of Vocational Rehabilitation.

PLANS FOR THE EXPANSION OF VOCATIONAL REHABILITATION SERVICES

As has been discussed in earlier sections of this report (eg. Analysis of State Agency Data, Public Hearings and Report of Interagency Survey), number one priority for expanding vocational rehabilitation services is the necessity for a wider geographic distribution of rehabilitation offices and facilities. The State Vocational Rehabilitation Agency presently has only fifteen district offices from which services are provided to disabled members of the general population. In the agency's B Budget request, there are provisions for opening twenty-four additional public offices. These offices are interspersed in major population centers throughout the state. At the present time, the agency has approximately seventy counselors in its existing offices who provide service to the general population. In their B Budget they are asking for an additional sixty-six counselors during the next biennium. According to estimation of need and recommendations made by the North Carolina Study in Vocational Rehabilitation, there will be a requirement for the establishment of forty additional offices with an office located in each county or group of counties with a population of at least 30,000 persons. The rationale for this recommendation is based on the presumption that for the Vocational Rehabilitation Agency to achieve a sufficient public identity and arrange for adequate interagency cooperation, it is necessary to have the widest geographic coverage possible. It was further estimated and recommended by the North Carolina Study in Vocational Rehabilitation that there is an immediate need for at least ninety-two additional counselors to serve the general population. Again, this recommendation is based on one counselor per 30,000 individuals. Again, this recommendation is based on one counselor per 30,000 individuals in the general population.

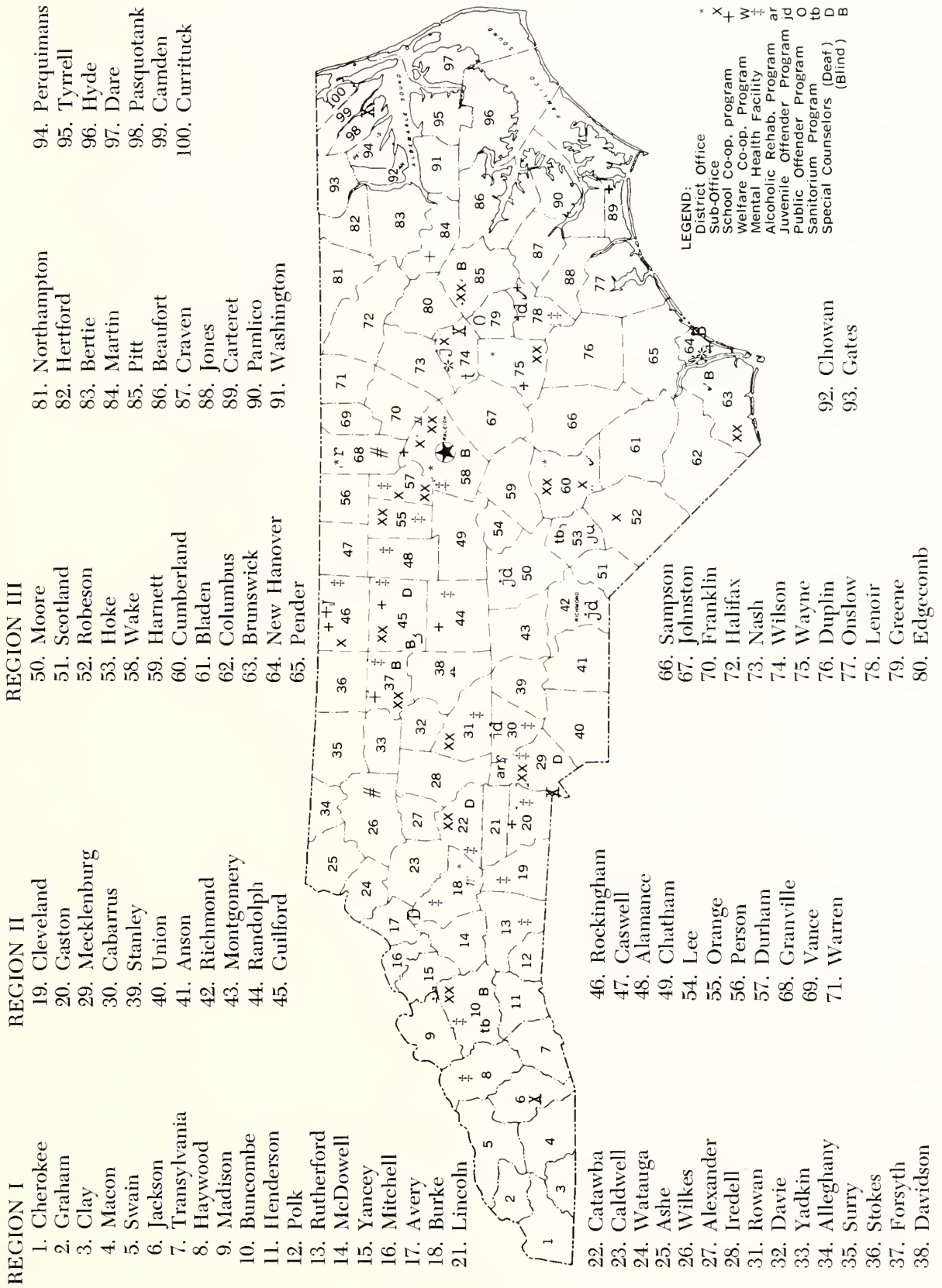
It is felt that the approval of the Agency's B Budget and the initiation of the plan presented in the B Budget is a group first step toward developing the organization and network of resources to meet the stated goal of providing services to the entire population of eligible handicapped people in the state by 1975. It is further felt that the locations outlined in the agency's B Budget for the placement of additional offices is appropriate. However, as the Agency formulates its plans for further expansion, not only of district offices, but also sheltered workshops, facilities and cooperative programs, it is felt that the development should be concentrated in the areas shown in Chapter IV to have a high degree of social and cultural deprivation and military rejecteeisms. For a discussion of the kinds of programs that probably should be initially developed in these areas see the section of Social and Cultural Deprivation and Military Rejectees in Chapter IV.

Another phase of expansion which should be mentioned is the agency's present plan for strengthening the administrative section of its program. Of utmost importance is the creation of positions of casework supervisor requiring a graduate degree in rehabilitation. To upgrade the professional service staff in the field, it is mandatory that professional supervision and guidance be provided. Also of utmost importance is the expansion of the agency's in-service training function. There should be a person in the central office with overall responsibility for developing a standard in-service training program that would be implemented uniformly by a staff of six field training officers responsible only to the state in-service training director. These individuals could provide training at the District Office level, thereby eliminating much counselor time that is spent in traveling to distant locations for training.

One other plan for expansion which seems to need immediate attention is the creation of a research unit to do research on specific problems as outlined in earlier pages. (See the recommendation on page 244.)

FIGURE 31

REGIONAL MAP OF NORTH CAROLINA STUDY IN VOCATIONAL REHABILITATION



CHAPTER VI CONTINUED PLANNING AND FOLLOW-UP

“Effective *citizen participation* is essential to effective services. This is easy to discuss and difficult to achieve. It is clear that to be effective, the citizen groups must have real power, for it is naive to expect that they will have a significant impact purely on the basis of goodwill. Among the kinds of power are political, economic (e.g. control of funds), technical, and the ability to enhance or inhibit agency effectiveness with key target groups”.¹

“Somehow the vested institutional interests and professional biases of various fragments of the helping services must be transcended by a *broader orientation*. This can be achieved in part by education, re-education, communication, etc.”²

¹Interagency Focus Memorandum No. 19, Interagency Relationships Project, October 9, 1968.

²*Ibid.*

“ORGANIZATION FOR COMMUNITY AND CITIZEN PARTICIPATION IN VOCATIONAL REHABILITATION AGENCY PROGRAMMING”

The *first major problem* identified by the Governor's Study Committee on Vocational Rehabilitation and all of its supporting groups was a lack of *public information concerning the Vocational Rehabilitation Agency* and its programs. A *great* deal of discussion by all participating groups has revolved around means by which the Vocational Rehabilitation Agency can have its public visibility increased.

The North Carolina Study in Vocational Rehabilitation has verified in all of its activities that there is a *severe* lack of knowledge concerning vocational rehabilitation activities both in the general population and among other social agencies, groups and organizations. These findings have been supported by interviews with a random sample of the population in three sample counties of the State. Further, support has been found in similar studies reported from other states, and also by the report of the *National Citizens Advisory Committee on Vocational Rehabilitation*.

The problem of low visibility has been recognized for a long time and has received much attention in public and private discussions, with little positive affect; therefore it may be assumed this problem's solution is not simple and will require considerable organizational effort before it is rectified. The following are some suggested techniques for reaching out and informing those needing rehabilitation services of their availability and at the same time creating an informed public that will encourage state and local governments to provide increased support for expanded service programs.

1. The Rehabilitation Agency should give considerable attention to strengthening its present public information program. The director of this service should be given the authority and freedom to give more direction to field persons assigned (part-time) to help him. These employees should be impressed with the importance of doing a concentrated job in the area of public information. They should work intensively with all local radio, television and newspaper media. Private moneys have been identified for developing a series of public service programs to be broadcast over local television stations; this project should be given *top priority*.

2. The public schools offer a perfect opportunity for reaching the young people of our society, some of whom may be in immediate need of service, some who are potential users of service, many who are future supporters of public programs and others who might be interested in pursuing careers which would meet the social service manpower needs of the future. Public schools have the *prerogative* as well as the responsibility to incorporate information of this type in their curriculum. Ideas for doing so have been discussed with officials in the Department of Public Instruction and submitted to the Department's superintendent. The Rehabilitation Agency's development section should initiate contact with the proper curriculum officials and offer encouragement, help, and consultation to the public schools for developing a program in this area.

Ideally, the curricular information just discussed should be incorporated into the public school program's existing social studies curriculum; however, it is believed that the feasibility for doing this successfully is highly questionable. Teachers, because of the demands already placed upon them, have very little time for uniformly including such information in a curriculum which is well structured by the text books used for courses.

Community Resources

Several units pertaining to community resources are proposed for inclusion in the existing seventh or eighth grade social studies curriculum. The purpose of these units is to give junior high age students some orientation concerning community services and training opportunities that are or will be available to them.

Objectives:

1. To provide information pertaining to the services offered by community agencies and organizations.
2. To provide information pertaining to agencies and organizations which offer training in a variety of areas.
3. To provide a means of encouraging young people to consider the service oriented professions for their life's work.

Background:

At the present time there are many community agencies and organizations which offer services and training. Young people entering the phase of deciding upon fields of employment often do not know of services which could be helpful during their preparation. They also have limited information pertaining to services which are provided by various agencies that they may need in their future. There should be some concern pertaining to how these services were developed, what their purposes are, and what benefits they offer for the general population.

In order for young people to become knowledgeable of the purposes, development and offerings provided through community agencies, they must receive information pertaining to these community services. The public schools are the appropriate agency to develop and provide this information because a knowledge of our communities is a fundamental part of one's education.

Implementation:

These units should be developed by personnel within the public schools. The most feasible approach is for the junior high school counselors, supervisors of guidance services and social studies teachers to work cooperatively in developing and providing the information.

The supervisors of guidance services could coordinate the overall development of these units on a local level. The junior high school guidance counselors could provide consultation services to the social studies teachers, provide information which would be obtained from the local agencies, and arrange for representatives from the local agencies to meet with the social studies teachers and students. The social studies teachers would have the responsibility of planning and developing the units and coordinate their work with the guidance counselors.

The above procedures would permit each local school system to develop the units according to their own needs and also provide the flexibility that would be necessary for each local school system.

Basic Plans for the Units:

These units are not merely viewed as ones which would only provide information but also units which would provide a maximum amount of discussion. The discussions could involve the services offered, how they were developed and what role each level of government had in the provisions of the services and training. Thus, a very basic part of the units would involve discussions of our governmental structure and how the various levels of government are organized. The units could also focus on the cooperation needed between the various agencies in order to coordinate and plan services.

Some agencies which should be included in the units are as follows:

- The Employment Security Commission
- The Department of Public Welfare
- The Department of Public Health
- The Division of Vocational Rehabilitation
- The State Mental Health Association
- Industrial or Technical Training Centers
- Community Colleges
- State Universities and Colleges—also Private
- Developmental Evaluation Centers
- The Y.M.C.A. and Y.W.C.A.
- The Manpower Development and Training Act
- New Careers
- The Social Security Commission
- Family Counseling Services
- Planned Parenthood Centers
- Local Associations for Retarded Children
- The Regional Educational Laboratory
- The Learning Institute of North Carolina
- Speech and Hearing Clinics
- Child Guidance Clinics
- School-Work Programs
- The Wright School for Re-education
- The Community Action Program
- Urban Renewal
- The Chamber of Commerce
- Legal Aid Society
- Better Business Bureau
- Tax Offices—City, County, State and Federal
- The F.B.I.
- Local Police Department
- Local Sheriff's Office
- Local Fire Department
- Goodwill Industries
- The Salvation Army
- The American Red Cross
- The United Fund
- Sheltered Workshops
- The State Department of Wildlife
- The State Department of Forestry
- The State Highway Patrol

Various State Institutions

- a. For the mentally ill, mentally retarded, emotionally disturbed, juvenile correction, adult prisons, etc.

The North Carolina Cerebral Palsy Hospital

Veteran's Hospitals

These agencies are only a representative sample of the many that are currently in existence. Each community could add others and some may be unique to particular areas. A study of agencies of this type would enable young people to become much more knowledgeable about services, training opportunities, potential areas of employment, the structure of government, the need for conservation of human and natural resources and the need for becoming informed about one's own community.

Any one of these agencies may be studied in detail and each local school system would be able to concentrate upon those which seemed more appropriate for their students. The information about each agency could include such aspects as:

1. Development of the Agency
2. Financing of the Agency
3. Operational Structure of the Agency
 - a. How one qualifies for the services or training
 1. Educational requirements
4. Residence requirements
5. Any limitations
 - b. How one obtains the services or training
 - c. Length of the services or training
 - d. Sponsorship of the agency—local, state or federal

Each school system could develop these units as they would be appropriate and could use information as well as representatives from the various agencies in order to obtain a practical and comprehensive view of each agency.

These units are considered as a very basic part of education in order to develop well-informed citizenry as well as provide a new approach for interesting young people in the service oriented professions.

Developed by: Don Shane

Member, Mental Retardation Task Force

3. There must be created a community organization (state as the community) through which communication with the total community, the resources which it is to be realized. This is a mandatory step if it is anticipated that adequate funding, support, coordination and cooperation necessary to achieve the stated goals of vocational rehabilitation are to be achieved. Included in this organization should be *Area Review and Advisory Boards* which correspond with the Agency's present area lines, *Review and Advisory Committees* primarily concerned with specific disability groups and a *State Review and Advisory Board* composed of elected representatives of the five area boards and a representative from each disability advisory group. Included in the State Review and Advisory Commission should be representatives from the committees previously created by the Vocational Rehabilitation Agency to advise on the development of sheltered workshops and facilities (see attached organizational chart).

Description of Boards

Area Review and Advisory Boards

The Area Review and Advisory Boards would have the responsibility for hearing at least annually and preferably semi-annually a complete review of the rehabilitation Agency's activities, plans and *problems* in their particular area. It seems that these boards would have considerable influence on program development in the area although not vested with authority for complete control. It is only reasonable to assume that these groups, who would have the privilege of being the best informed citizens in the area regarding vocational rehabilitation, should influence program development. If the Agency cannot secure the Board's endorsement for proposed new developments, it should be clear that more ground-work for developing support from the community should be done before the development is undertaken.

Other duties of these boards would be to advise the Agency of unmet area needs requiring attention and to communicate with their communities regarding the fullest utilization of and coordination with the social service programs. The Agency's responsibility to each area's Review Board would be to provide the board with a complete review of all its present activities and ideas for expanding the area's rehabilitation resources. Special emphasis should be placed on discussing with the Review Board problems being confronted so that their ideas can be solicited.

The Review Board at the area level should consist of one person representing each county in the area, the persons having been appointed by and responsible for reporting back to the *Board of County Commissioners*. *The Agency's area director would have responsibility for being the permanent secretary for Review and Advisory Board* and providing assistance to the elected officers of the Board in carrying out their responsibilities.

Disability Review and Advisory Committees

The Disability Review and Advisory Committees should be appointed by the appropriate disability association such as The North Carolina Mental Health Association, The Association for Retarded Children, United Cerebral Palsy, The North Carolina Speech and Hearing Association, the North Carolina T.B. and Pulmonary Diseases Association, the North Carolina Heart Association, the North Carolina Society for Crippled Children and Adults, the North Carolina Epilepsy Foundation and other Disability Review and Advisory Committees should be appointed by whatever public or private body is most concerned with the condition. These groups would have the responsibility for receiving a complete review of the Vocational Rehabilitation Agency's activities for special disability groups from an appropriate state level official of the Division. Such a procedure should guarantee a dialogue between the Vocational Rehabilitation Agency and the State's various organizations concerned with the betterment of disabled and handicapped people. It would also give the disabled an opportunity to call to the attention of the Rehabilitation Agency social service needs being unmet for particular groups.

These committees should be appointed by the executive body of the particular association and each committee should have assigned to it by the director of the Division of Vocational Rehabilitation an appropriate rehabilitation officer who could act as permanent secretary to the committee.

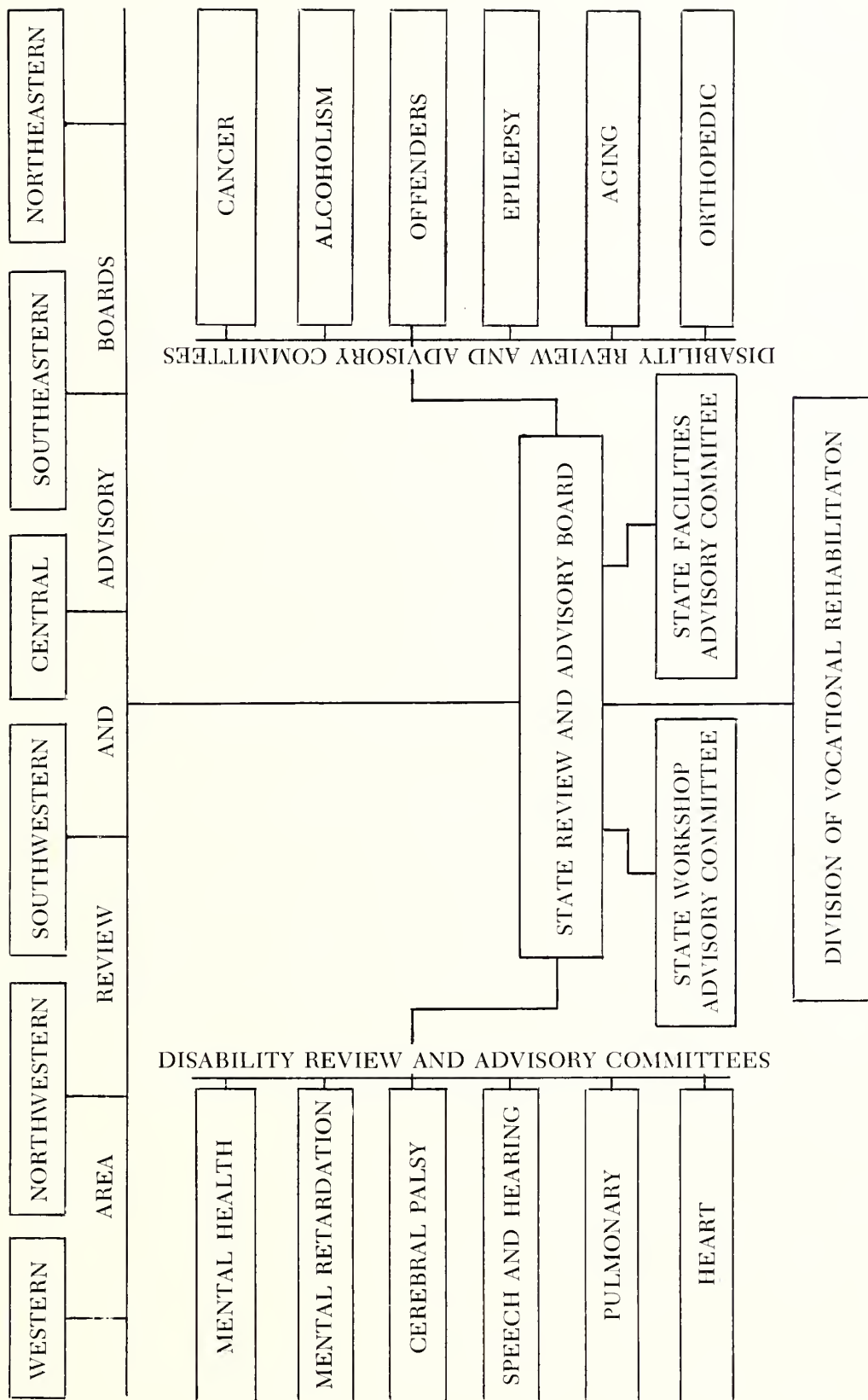
State Review and Advisory Board

The State Review and Advisory Board should consist of one representative from each of the area Review and Advisory Committees, the Disability Review and Advisory Committee, the State Advisory

Committee on Workshops, the State Advisory Committee on Facilities, a representative of the Department of Administration and a representative appointed by the Legislative Committee of the North Carolina State Legislature. Committee responsibility would be to bring together the concerns and recommendations of each unit represented. The permanent secretary of this group should be the director of the Division of Vocational Rehabilitation. The State Review and Advisory Board should meet at least annually and the meeting should be long enough to allow all concerns from various units to receive needed attention. The State Review and Advisory Board and all the subunits should present an annual written report to help the Agency establish priorities for strengthening the programs which it offers to particular disability groups and in particular geographic areas of the State.

This proposed system of organization would not only give the Agency the privilege of having the guidance and direction of a broad segment of the State's society but each unit would also represent a liaison body between the Agency and the general public; thereby increasing the utilization of Agency services and the base of support from which the Agency has to operate.

Figure 32
ORGANIZATION FOR COMMUNITY AND CITIZEN PARTICIPATION
IN VOCATIONAL REHABILITATION PROGRAMMING



Structure for Continuation of Planning

In order to effectively implement the previously described program which is so essential for growth, development and support, the State must maintain a planning staff. This staff should concentrate its attention on creating the organization previously described and coordinating and implementing the organization's effectiveness. The staff should also have at its disposal sufficient resources to do research on practical problems of rehabilitation. Some of these problems and areas of needed research have been described previously in this report.

It is felt that responsibility for this activity should be vested in a unit created within the *Department of Administration* and related to the *State Planning Task Force*. Such a position in the state's structure of Government would lend itself to the "commission" having a broader perspective than would be possible were it officially attached to a particular service agency. As has been previously mentioned and implied many times in this report, rehabilitation does, and must, depend on the coordination of the services of *all* social service agencies.

An organization with adequate clerical and statistical staff to provide managerial material presently unavailable is needed. The mission of this organization would be to maintain the involvement of local citizens, state and local agencies and to keep them informed of the issues and problems needing to be resolved if this state is to achieve maximum effectiveness of its rehabilitation efforts.

In addition to maintaining the existing citizen participation and creating a structure for expanded citizen and community involvement, a *Rehabilitation Research and Coordination Council* in the Department of Administration could aid in the establishment of effective communication among *all* state service programs that minister to *individuals* and *families*. It would seem that such an organization would do much in eliminating and preventing overlapping and duplication of rehabilitation activities and would insure that programs for *all* agencies are complementary, thus having a pyramiding effect. The Rehabilitation Research and Coordination Council would give the administration and the legislature a formal mechanism for maintaining closer liaison with programs serving individuals.

On the basis of the experience of the North Carolina Study in Vocational Rehabilitation, a budget of at least \$85,000 a year should be created for the purpose of instituting a Rehabilitation Research and Coordinating Council in the Department of Administration. Information from the Rehabilitation Services Administration indicates that matching money would be available from that branch of government for the operation of this activity. On the basis of an 80:20 matching ratio, a state appropriation of \$16,000 would be needed to make this plan a reality. This effort, like rehabilitation itself, is believed to be an administrative cost that would pay for itself many times over. All possibilities for creating a permanent rehabilitation council should be explored.

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